The Department
of Veterans Affairs
Employee Education System

Care Management in VA

A Tool Kit for Care/Case Managers

Employee Education System

Department of Veterans Affairs

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VETERANS AFFAIRS
EMPLOYEE EDUCATION SYSTEM

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MARCH 2001

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INTRODUCTION

Our nation's health care and patient demographics are undergoing tremendous changes; however, resources are not expanding at a rate consistent with the increasingly more complex, long term health care needs of veterans.

Consequently, care must be available not only within the hospital setting, but also offered within the home and community. Care/case management provides a process of coordinating health care across all settings for all stages and episodes of illness at the appropriate level of care.

This tool kit for Care/Case Managers contains a variety of VHA and commercial resources for the person who coordinates the patient's care across the continuum. Titles for this position vary among facilities. Throughout this tool kit the title Care/Case Manager will be used to designate this role.

Among the materials included in this tool kit are information about helpful web sites. One on-line resource, Case Management Resource Guide, at http://www.cmrg.com is especially comprehensive.

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ORIENTATION TO THE ROLE OF CARE/CASE MANAGER

CASE/CARE MANAGER ORIENTATION CHECKLIST

Employee Name _____ **Supervisor** _____

	Supervisor Initials	**Employee Initials**	**Date**
1. Introduction to:	_____	_____	_____
( ) Supervisory staff			
( ) Service Chief/Product or Service Line Manager			
( ) Clerical staff			
( ) Service/Product line peers			
( ) Interdisciplinary team members			
2. Review of:	_____	_____	_____
( ) Position description/Functional statement			
( ) Performance standards/competencies			
( ) Job responsibilities			
( ) Productivity standards			
( ) Supervisory expectations			
( ) Clinical privileges/Scope of practice			
( ) Licensure requirements			
( ) Mandatory training			
( ) Continuing education requirements			
( ) VHA Clinical Practice Guidelines			
( ) VHA Nursing Qualification Standards(as appropriate)			
( ) VA HQ "Windows to Primary Care SWS Field Guide" (as appropriate)			
( ) Policy manual/protocols			
3. VA Organizational Overview:	_____	_____	_____
( ) Department of Veterans Affairs			
( ) VHA Headquarters			
( ) VISN structure			
( ) Medical Center organization			
( ) Community-Based Outpatient Clinics			

4. Overview of: _____ _____ _____

( ) Medical Center mission and vision
( ) Service/Program mission, vision and functions
( ) Director's Performance Measures
( ) Managed Care & VHA strategic initiatives

5. Overview of Services:

( ) Medical Programs (as appropriate) : _____ _____ _____

- Primary Care
- Ambulatory Care clinics/programs
- Inpatient care
- Surgery programs
- Medicine programs
- Neurology
- Rehabilitation
- Emergency Department
- Persian Gulf Veterans
- Ex-POW Program
- SCI Unit/Coordinator
- Observation/lodger beds
- Other _____

( ) Extended Care Programs (as appropriate) : _____ _____ _____

- Extended Care/Nursing Home Care Unit
- Geriatric Program/Clinics
- Domiciliary
- Respite Care
- Home-Based Primary Care (HBPC)
- Community Nursing Home Program (CNH)
- Homemaker/Home Health Aide (H/HHA) Program
- Contract Adult Day Health Care (ADHC)
- Other _____

( ) Mental Health Programs (as appropriate) : _____ _____ _____

- Psychiatry Primary Care
- Mental Health Clinic
- Trauma/PTSD Program
- Substance Abuse Treatment
- Inpatient Psychiatry
- Transitional living programs
- Other _____

6. Overview of Other Programs/Services (as appropriate): _____ _____ _____

( ) Emergency welfare fund for indigent veterans

( ) Hoptel or other overnight accommodations programs

( ) Advanced directives

( ) Compensation & Pension (C&P) exams

( ) (Visual Impairment Services) VIST/Blind Rehab

( ) Women Veterans program/coordinator

( ) VA attorneys/Regional Counsel (guardianship)

( ) Public Affairs/Marketing Office

( ) Patient Representatives/Advocates

( ) Use of GSA vehicles

( ) After hours coverage

( ) VA Benefits and Eligibility:

- VA Enrollment System (7 enrollment groups)
- SC compensation and priority for services
- NSC status and pension
- Aid & Attendance, Housebound status
- CHAMPUS & CHAMPVA
- Prosthetics & Equipment (incl HISA grants)
- Home Oxygen
- Dental & Eye Clinics
- Fee Basis Care
- Inpatient admissions/InterQual standards
- Beneficiary travel
- VA Regional Office (Veterans Benefits Counselors)

( ) Community Resources:

- Voluntary Service and volunteers
- Veterans Service Organizations (American Legion, DAV, VFW, VVA, PVA, etc.)
- State department of veterans affairs
- State department of human/social services
- State veterans homes/domiciliaries
- State psychiatric hospitals
- Public hospitals
- Private hospitals/clinics/services
- Affiliations with schools of medical/nursing/social work/other allied health
- State, county and/or city offices of senior affairs/services
- Meals on Wheels
- Assisted living facilities
- Board and Care/Residential Care homes

- Rape crisis/domestic abuse resources/shelters
- Homeless services/shelters
- HUD & other subsidized housing
- Hospice programs/services

7. Tour of Facility and Program Area: _____ _____ _____

8. Instructions: _____ _____ _____

( ) Telephone system (local and FTS)
( ) Paging system
( ) Consulting other providers/programs

9. Instructions on using VistA: _____ _____ _____

( ) Mailman & mail groups
( ) Electronic progress notes, CPRS, GUI
( ) Entering workload/Event Capture
( ) Accessing patient data
( ) Electronic consults
( ) Electronic leave requests
( ) Use of printers
( ) FORUM
( ) MS Exchange/Outlook

10. Workload & Productivity: _____ _____ _____

( ) Cost Distribution Reports (CDR) reports
( ) DSS labor mapping
( ) HCFA diagnostic & procedure codes
( ) Work units & Relative Value Units (RVUs)
( ) Practitioner-specific workload reports
( ) Billing and MCCF

11. Applicable Medical Center Policies: _____ _____ _____

( ) Performance appraisals/proficiencies
( ) Leave usage (include Family Friendly Leave)
( ) Incentive awards program
( ) State laws on adult/child abuse and neglect reporting
( ) Medical Center patient abuse policy
( ) Breaks and lunch
( ) On-the-job injuries
( ) Documentation standards
( ) Ethics referrals
( ) Confidentiality
( ) Employee health

( ) Smoking policy
( ) Program specific policies

12. Review of meeting schedules: _____ _____ _____

( ) Staff meetings
( ) Program area meetings (treatment/discharge rounds, patient conferences, etc.)
( ) In-service training
( ) Journal club

13. Committees: _____ _____ _____

( ) Service/Product Line Committees
( ) Medical Center Committees

14. Orientation to Performance Improvement (PI): _____ _____ _____

( ) Mandatory PI training hours
( ) Medical Center PI Committee
( ) Chartering teams
( ) Practice evaluation
( ) Supervisory chart audits/Peer review
( ) JCAHO standards & surveys
( ) The Rehabilitation Accreditation Commission (CARF) standards & surveys

15. Mandatory Training: _____ _____ _____

( ) Fire and Safety
( ) Hazardous Communication
( ) Utility Management
( ) Disaster Plan
( ) Universal Precautions
( ) Security
( ) Patient Rights
( ) HIV/AIDS
( ) Customer Service
( ) Standards of Ethical Conduct Review
( ) EEO (including complaint process)
( ) Sexual Harassment
( ) Other_____

EMPLOYEE SIGNATURE: _____ **Date:** _____

SUPERVISOR SIGNATURE: _____ **Date:** _____

CARE/CASE MANAGER: GENERIC TITLE V JOB DESCRIPTION

This sample provides guidance on structure and types of information to include in developing the above position. It is intended that it be tailored to local needs and specifications.

Care management in the VA is a mechanism for increasing the likelihood of a patient receiving easily accessible, coordinated, continuous, high quality health care. Care management is that aspect of primary care that coordinates care across all settings, including the home. VA care management is patient-centered rather than disease-specific; coordination of care for all diseases and all episodes of illness is carried out by the care/case manager assigned to a particular patient.

Major Duties:

The incumbent provides direct patient care to an adult population of predominantly older, male patients. The individual must demonstrate the knowledge of the changes associated with aging and possess the ability to provide care based upon age-related factors as noted in age-specific competencies described in service and unit policies and procedures. The VA care/case manager especially focuses on the patient in the context of family and community by integrating an assessment of living conditions, individual and family dynamics, and cultural background into the patient's plan of care.

The care/case manager is responsible for providing the appropriate intensity of care management for his/her panel. It is recognized that manageable panel sizes will vary depending on the case-mix of the panel. Care management is focused primarily on providing more coordinated and higher quality care; it may or may not lower the cost of care.

The care/case manager provides and coordinates services by assessing the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.

The patient care services are carried out in full accordance with the broad program goals of the VA health care system. Within these broad categorizations, the care/case manager must tailor patient care/support services by assessment of each patient's needs and delivery of services that are responsive to the concerns of individual patients to the extent possible. The care/case manager establishes methods for tracking patients' progress and evaluating effectiveness of care, as well as maintaining appropriate documentation of each patient's care and progress within the plan.

Factor 1. Knowledge Required by the Position

The employee must be able to demonstrate the knowledge and skills necessary to provide care appropriate to the age and complexity of the patients served in his/her assigned service area. The individual must demonstrate knowledge of the changes associated with aging and the principles of growth and development relevant to the adult and geriatric patient group. Incumbent must have knowledge and the ability to apply developmental theory and age specific issues. He or she must be able to access and interpret data about the

patient's social, emotional, mental health, medical needs and provide the care/services needed. The care/case manager must have knowledge of the vast array of VA, federal, state and local community agencies and resources and how to access and coordinate those services along with knowledge of clinical pathways and calculation of variances to the pathway.

The employee must be able to demonstrate the knowledge and skills as identified in the Competence Assessment Checklist appropriate for the position. The employee must demonstrate knowledge and skills in interpersonal relations, especially the ability to appropriately, professionally and courteously relate to internal and external customers. Employee must demonstrate the knowledge and skills to complete job assignments and to safely and correctly operate equipment necessary to complete the duties of the position. The employee is required to meet minimum OPM Qualification Standards for General Schedule Positions and/or VA Qualification Standards, MP-5, Part 1, Chapter 338.

The incumbent has knowledge of population characteristics including cultural, ethnic, gender, and religious diversity.

He/she must have knowledge of family dynamics, psychotherapy, developmental theory and interpersonal relationships and systems approach to care.

Incumbent maintains knowledge about disease processes, disabilities, medications and their biopsychosocial sequelae. Participates in regular peer review and Quality Improvement processes.

Incumbent may serve as a preceptor or field instructor for students at the undergraduate, graduate or doctoral level.

Care/Case Manager must have knowledge of current VA and non-VA entitlements and benefits.

Must have knowledge of terminal illness and end of life planning processes.

He/she must have knowledge of medical economics.

Incumbent must have knowledge of medical legal, ethical issues and requirements.

Must also have knowledge of VA and community resources and how to access them.

Factor 2. Supervisory Controls

Supervision is of a consultative nature and is usually arranged at the care/case manager's request to seek assistance with unusually complicated direct service work and for clarification of administrative issues. In the performance of the majority of activities, the incumbent exercises independent professional judgment working in the context of a multidisciplinary team. The ability is required to make independent decisions when working with the primary care team/provider while remaining an advocate for the patient/family.

Factor 3. Guidelines

Incumbent is guided by VA Headquarters' directives, Medical Center policies and bulletins, procedures, supervisory instructions and guidance. Highly developed professional skills, flexibility, mature professional judgment, and use of a variety of advanced treatment modalities are required to make assessments and to intervene in complex and emergent case situations.

Factor 4. Complexity

In performing his/her duties, the incumbent works with clients whose socioeconomic and health-related

problems vary in complexity. Because the level of difficulty frequently cannot be determined prior to the Care/Case Manager's involvement in individual cases, the incumbent must independently make sound treatment decisions based on assessments, sometimes utilizing standardized assessment tools, and skillfully execute interventions for the most difficult cases. In all cases, the Care/Case Manager must make accurate and continual assessments of the patient's biopsychosocial problems and needs, and be aware of procedures to protect the patient physically and financially. The incumbent must be able to effectively work with clients and families. The Care/Case Manager provides assistance, information and support to patients/families in coping with emotional, practical and lifestyle issues which accompany advancing age and physical, sensory and cognitive impairments. He/she assists with development of processes to coordinate care along the continuum encouraging exploration of creative alternatives for care, enhancing communication with others, and helps to screen for problems that should be brought to the attention of the primary care provider. Assessment skills are appropriately utilized while articulating to members of the primary care team the needs of the patient. Initiative is taken to monitor appropriate level of care and length of stay in acute care to ensure cost effective care. While cost is a consideration, the overall goal of the Care/Case Manager is to assure that the patient has the appropriate level of care and services to meet the social and health care needs.

The incumbent may also perform a variety of mediating roles in promoting effective and efficient use of treatment services and the health care system.

Factor 5. Scope and Effect

The Care/Case Manager is responsible for developing and implementing in collaboration with the Primary Care Team/provider the biopsychosocial treatment plan, and coordinating care across all settings, including the home. This responsibility requires considerable expertise and skill, as well as maintenance of an effective balance between the needs of the patients and families and the priorities of the Medical Center and the VA health care system. The challenge of this assignment lies in skillfully developing an effective biopsychosocial treatment plan for patients who are seriously compromised by chronic illness, mental health, social, financial and other related conditions. The consequences of the actions taken may be serious because the veteran may be in an especially vulnerable position due to cognitive, sensory and functional impairments.

Factor 6. Personal Contacts

The incumbent must continually relate in a professional manner to primary care providers, members of the multidisciplinary team, as well as to patients, family members, students in training, representatives of various community agencies, and other medical center administrators and employees. In those contacts and in every-day decisions, the incumbent is expected to perform effectively in the absence of immediate access to supervisor.

Factor 7. Purpose of Contacts

The Care/Case Manager must assess and provide individual, family and group treatment; consult and plan with the multidisciplinary team; provide information to community agencies and inform supervisory staff of patient care activities. He/she also supervises/evaluates aspects of care provided by non-VA providers.

Factor 8. Physical Demands

The work is primarily sedentary, but requires some walking, standing, bending, and carrying of light items such as books, papers and laptop computers. Some community visits may require the ability to drive a vehicle.

Factor 9. Work Environment

The incumbent works primarily in an office, however, he/she may see clients in a variety of treatment settings, such as group therapy rooms, inpatient wards, outpatient treatment rooms, and patients' own homes. Incumbent abides by VA safety rules and regulations, and promotes safe behavior within the Program and among co-workers. Position may require some travel outside the Medical Center.

TITLE 38: GENERIC FUNCTIONAL STATEMENT FOR CARE/CASE MANAGER

This sample provides guidance on structure and types of information to include in developing the above position. It is intended that it be tailored to local needs and specifications.

A. ROLE DEFINITION:

The Care/Case Manager coordinates care across the continuum for a select group of clients. He/she provides professional guidance, coordination and planning of multiple health care services; acts on behalf of the client to assure that necessary services are received and that progress is being made; and provides ongoing evaluation of care management services.

B. QUALIFICATIONS:

1. Meets all the basic requirements for Title 38 appointment in the Veterans Health Administration.
2. Educationally prepared at the baccalaureate level or higher.
3. Minimum of three years of successful clinical practice.
4. Demonstrated ability in the areas of interpersonal relations, critical thinking, problem-solving and conflict resolution.

C. FUNCTIONS AND RESPONSIBILITIES:

1. Clinical Practice

- Provides initial and ongoing assessment of patients to identify needs, issues, resources and care goals, and identifies resources and critical factors for achieving desired outcomes for discharge, post hospitalization recovery and health maintenance/improvement.
- Sets care related goals, short and long term, in collaboration with patient, provider, and significant others.
- Functions as a systems coordinator for the plan of care; monitors progress through the expected hospital course and intervenes as appropriate to facilitate achieving patient outcomes within anticipated timeframes. Coordinates care and discharge planning with the patient's primary care provider and team.
- Collaborates with patient and care providers in any and all settings where care is being provided to evaluate and update changes in the therapeutic plan of care and patient management.
- Advocates fiscal responsibility in the management of patient care through effective utilization of resources.
- Recognizes impact of age-specific care needs and incorporates this into the assessment process. Also, incorporates these age-specific needs into care as reflected by modification of pathways.

- Maintains a working knowledge of resources available in the community
- Screens patients for social service, home care, and other community care needs; and coordinates or makes referrals as appropriate; and seeks consultation when indicated.
- Appropriately documents own interventions and oversees appropriate health team documentation of patient care.
- Keeps patient's provider and team aware of patient progress, issues, and/or problems.
- Tracks and trends issues related to care delivery and participates in quality improvement activities to reverse problematic issues.
- Maintains a flexible schedule that accommodates the needs of patients/significant others, as well as the needs of the health team.
- Bases practice on current knowledge/technological advances and/or research findings.
- Participates in research-related activities as appropriate.
- Identifies personal learning needs and assumes responsibility for own professional growth.
- Initiates change in practice based on review of the literature.
- Develops, coordinates and presents educational media programs toward improving productivity, patient outcomes and treatment modalities.

2. Interpersonal Relationships

- Works collaboratively with interdisciplinary groups in a cohesive manner.
- Communicates effectively with patients, families/significant others and the health team members.
- Facilitates open dialogue among peers, supervisors and staff.
- Evaluates needs and facilitates the patient's ability to learn the principles of self-care; utilizes appropriate resources if the patient is unable to grasp the knowledge/skills needed for self-care.
- Evaluates need and initiates interdisciplinary ad hoc committees/process action teams for constructive problem-solving.
- Establishes ongoing relationships with professional/health related groups within the community.
- Serves as a preceptor for students seeking learning experiences on a graduate level and evaluates outcomes.
- Recognizes complex situations that impact patient care and intervenes, using sound judgment, professional attitude and appropriate channels.
- Fosters good public relations when interpreting philosophy, policies/procedures, goals and objectives to staff, patients and the public.
- Actively listens to customer feedback, positive and negative, and acts to resolve issues within span of control or networks to resolve issues with those who have authority to bring about resolution.

VA CARE/CASE MANAGERS

Recommended Competency, Skills and Knowledge Requirements*

Competencies:

Ability to conduct a comprehensive biopsychosocial assessment.

Ability to activate individual and family treatment interventions.

Ability to educate patient and family regarding benefits and risk factors for optimal biopsychosocial functioning, community resources, wellness and health promotion to enhance shared decision-making.

Ability to mobilize patient and family to utilize coping strengths and VA/community resources.

Ability to work with a variety of professionals, agencies, and systems.

Ability to educate professional and non-professional VA/community providers regarding biopsychosocial factors and family dynamics impacting response to treatment.

Ability to communicate and negotiate with all levels of the organization regarding system's problems and recommended solutions.

Ability to mobilize an array of VA and community resources and services.

Ability to identify gaps in services, develop and utilize alternative resources.

Ability to organize and prioritize.

Knowledge:

Knowledge of population characteristics to include cultural, ethnic, gender, and religious diversity.

Knowledge of family dynamics and interpersonal relationships.

Knowledge and application of developmental theory and age specific issues.

Knowledge about disease processes, disabilities, medications and their biopsychosocial sequelae.

Knowledge of current VA and non-VA entitlements and benefits.

Knowledge of medical economics.

Knowledge of medical legal, ethical issues and requirements.

Skills:

Skills in written and verbal communication.

Skills in advocacy.

Skills in counseling to facilitate life changes.

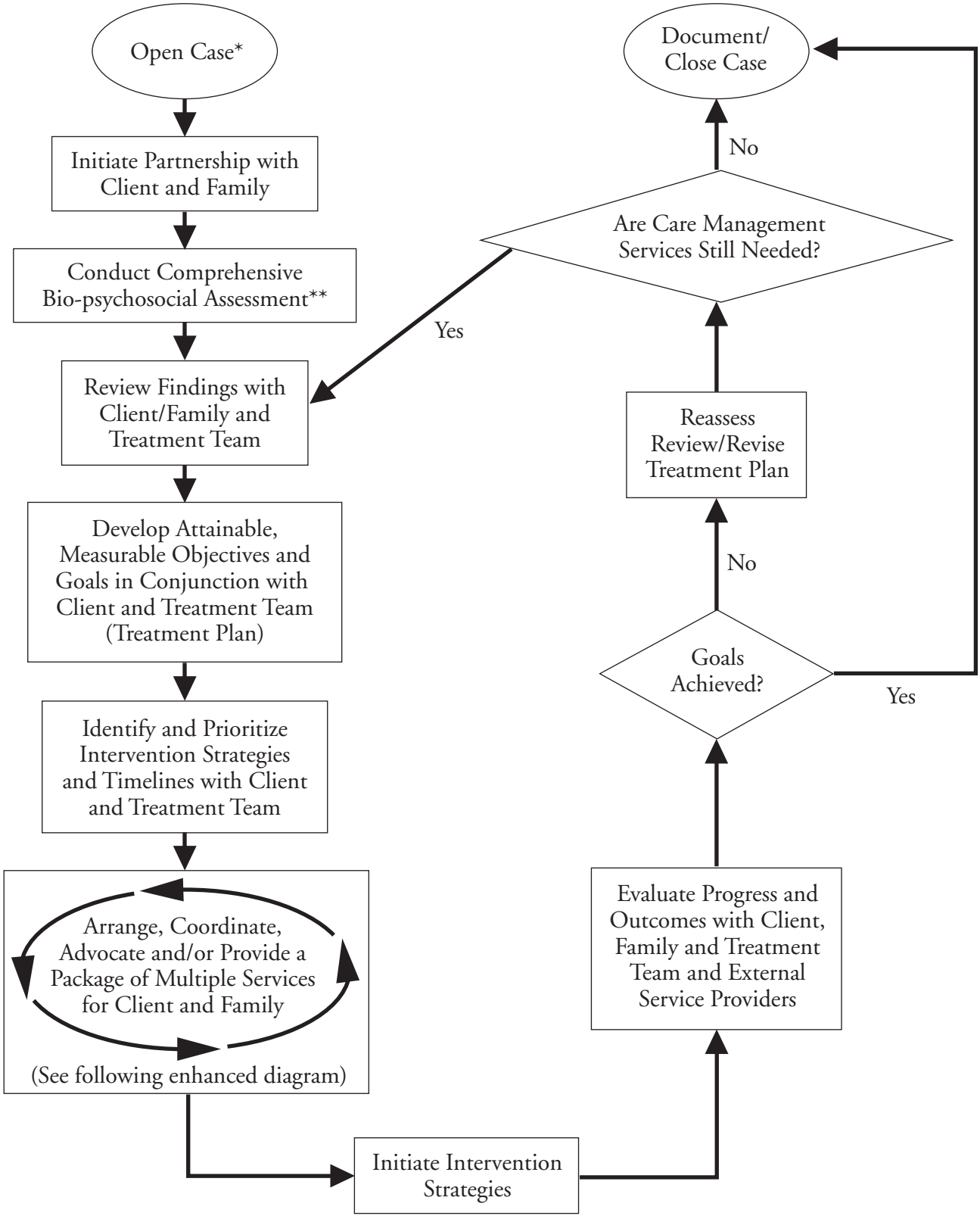
Skills in conflict management and mediation.

Skills in negotiation.

Skills in coordination, organization, prioritization, and delegation.

*Adapted from Social Work Practice Guideline, Number 2, p. 13. A National Center for Cost Containment publication, September 1995.

Care Management Flow Chart



* This assumes that the patient has been screened and identified as in need of care management services

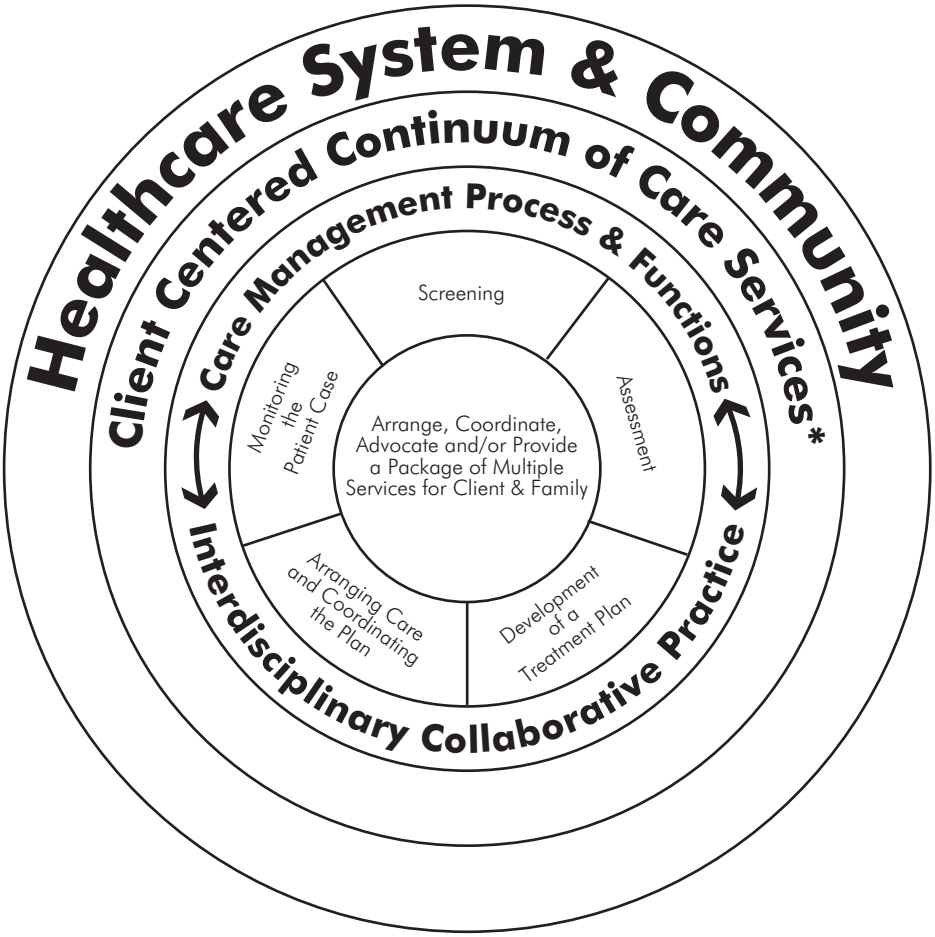
** See previously published guideline on Phycosocial Assessment

Adapted from Social Work Practice Guideline, Number 2, p. 13, 1995. A National Center for the Cost Containment publication.

COLLABORATIVE PRACTICE NATURE OF CARE MANAGEMENT, THE RANGE & COMPLEXITY OF SERVICES PROVIDED & THE ENVIRONMENT IN WHICH ALL OF THIS OCCURS*

Continuum of Care Services

Hospital
Home health care
Nursing Home
Hospice
Durable medical equipment
Infusion services
Nutrition services
Personal care
Homemaker
Home maintenance services (repairs)
Respite care
Adult day care
Transportation
Physician services
Ambulatory care
Wellness programs
Primary care
Assisted living program
Senior centers
Other VA & Community programs & services
Mental health services
Domiciliary
Residential Care
Family/caregiver support services
Vocational/employment
Adult protective/legal services
Financial services
(This is not an all inclusive list)



*Adapted from Social Work Practice Guideline, Number 2, p. 13, 1995. A National Center for Cost Containment publication.

CARE/CASE MANAGEMENT JOB NEEDS

1. A clear definition of the mission of the Care/Case Manager at their facility.

2. An explicit statement of who is clinically responsible for the patients; for example, the managing physician's and his/her backup's responsibility for:
    a. ordering
    b. prescribing
    c. workload capture
    d. billing
    e. initiation of requests for in-house and non-VA services
    f. progress notes
    g. periodic reviews

3. Orientation to the following: (See also Orientation Checklist.)
    a. Department of Veterans Affairs, Veterans Health Administration, VISN (Network), local facility, services, service/product line, political stakeholders, service organizations, MAS, Fiscal, HRMS, VERA, etc.
    b. Community resources such as: VNA, Home Care Agencies, Meals on Wheels, local and regional transportation systems, senior adult programs, adult protective programs, etc.
    c. VA programs such as: travel, pharmacy, nursing home care, adult day care, domiciliary care, substance abuse, homeless programs, residential care, respite, etc.

4. Suggested/Recommended individual needs at the facility:
    a. A private office with accessible conference space large enough for 4-6 persons
    b. Secretarial support, including computers, copiers, fax, reproduction; E-mail; Outlook, etc.
    c. Furniture
    d. Computer: PC and laptop, printer, fax, CD-ROM, access to VISTA, Outlook, Internet, Intranet, Network, MicroMedics (pharmacy software package), speakers
    e. Telephone; voice mail/answering machine; cell phone; pager
    f. Vehicle
    g. Storage space
    h. Appropriate equipment, i.e., VCR, television monitor, etc.
    i. Educational references: textbooks, journals, videos, CDs, etc.
    j. Access to the Learning Maps, especially on VA finances

5. Access to paid educational programs, relevant to care/case management as well as the primary discipline.

6. Scope of Practice, defined and driven by their primary discipline/professional status, and clinical privileges.

7. Knowledge of licensing, certification and continuing education requirements of the state and VHA.

8. A defined Functional Statement (FS) or Position Description (PD), in which the Care/Case Manager helped to develop. This is FS or PD discipline-specific with tailored elements defined for facility/service/section/program needs.

9. Definition of Patient Panel:
    a. Size
    b. Complexity
    c. Inpatient, outpatient care or both
    d. Criteria for admission into care management program; any automatics; any defaults
    e. Criteria for discharge from program; any automatics; any defaults
    f. Defined pathways for problem resolution (programmatic or patient)

10. Defined statement of who does proficiency or performance appraisal.

11. Access to:
    a. Clinical Practice Guidelines
    b. Formularies, pharmacy
    c. Prosthetics
    d. Patient Assessment tools
    e. Infection Control
    f. Police and Security
    g. Patient Representative
    h. Risk Manager
    i. Internal and external reviews of the program or individual patient records, such as JCAHO, InterQual, EPRP, CARF, etc.

12. Definition of procedures for crossing service lines when patient needs require, including a statement of who pays when service lines are crossed.

13. Defined goals: short term and long term; participation in goal development.

14. Defined outcome measures: participation in outcome measures development and modification.

15. Defined treatment plans: participation in treatment plan development and modification.

POLICIES

VA DIRECTIVES

The following is a list of VA directives that may be particularly helpful to Care/Case Managers. Go to http://www.va.gov/publ/direc/default.asp or vaww.va.gov/publ/direc/health/

98-006, Smoking Policies for Patients in VA Healthcare Facilities, 1/16/98

98-013, Social Work Professional Standards: Accreditation and Reimbursement from Third Party Payers, 2/23/98

98-022, National Home & Community-Based Care Strategies, 4/1/98

98-023, Guidelines for Implementation of Primary Care, 4/17/98

99-006, Pension Threshold for Determining Beneficiary Travel Eligibility, 3/2/99

99-010, Health care for Veterans of Persian Gulf war and Future Conflicts, 3/23/99

99-019, VA Funded Examination Program for the Spouses and Children of Gulf War Veterans, 5/3/99

99-027, Treatment of Tricare Beneficiaries at VA Medical Facilities, 6/22/99

99-030, Authority for Mental Health Program Chances, 6/30/99

98-022, National Home and Community-Based Care Strategy 4/1/98

96-031, Purchase of Homemaker/Home Health Aide Services 4/16/96

99-033, Guidelines for Use of Expanded Role Health Providers 2/99

Prescribing Authority (AD)

10-94-028, Integration, Coordination & Management of Long Term Care

IL 10-99-003,Utilization of Nurse Practitioners & Clinical Nurse Specialists

10-95-019, General Guidelines for establishing Medication Prescribing Authority for Clinical Nurse Specialists, Nurse Practitioners, Clinical Pharmacy Specialists and Physician Assistants

June 3, 1999

VHA PROGRAM GUIDE 1103.3

Department of
Veterans Affairs

MENTAL HEALTH PROGRAM GUIDELINES FOR THE NEW VETERANS HEALTH ADMINISTRATION

Office of Patient Care Services
Mental Health Strategic Healthcare Group (116)
Veterans Health Administration
Washington, DC 20420

FOREWORD

Guidelines as set forth in this document are published to improve the care for a large and often complex group of veteran patients. These Guidelines reflect what the Veterans Health Administration (VHA) is capable of doing now and suggest directions for future program development, particularly in response to the revolutionary changes accompanying the Journey of Change. The Department of Veterans Affairs (VA) operates a large, diverse healthcare system that must adapt, create, lead, and innovate, or it will not meet the needs of veterans of future decades. VA strongly encourages the creation of new, evidence-based, innovative programs, organizations of clinical services, and alliances with, and input from, community organizations, as it moves from a predominately hospital-based system to one based in, and serving the entire veteran community.

This organization of mental health services, based on the concept of an integrated continuum of care should be incorporated into the regular VA planning process at all levels. If additional resources are required to provide necessary services, requests should be incorporated into the planning process at the Veterans Integrated Services Network (VISN) level.

These are guidelines. None of the programs listed are mandated at this time. It is strongly encouraged to use the enclosed definitions, Decision Support System (DSS) Identifiers, Treating Specialty Codes, and Cost Distribution Report (CDR) Accounts at all sites so that we can share meaningful information among medical centers and across Veteran Integrated Service Networks (VISNs).

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Distribution: RPC: 0050
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Printing Date: 6/99

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MENTAL HEALTH PROGRAM GUIDELINES FOR THE NEW VETERANS HEALTH ADMINISTRATION

APPENDIXES

(Only selected pages of the Mental Health Program Guidelines are reproduced here.)

(4) Case (Care) Management. Case (care) management should be made available when indicated.

(a) Definition. Case (care) management is a strategy for coordinating and integrating care among providers and systems in order to achieve optimal client outcomes, reduce costs, enhance quality, and promote continuity across the healthcare continuum (Laura Miller, 1997). In the mental health care area, use of case management with high risk populations of veterans can enhance continuity of care, accessibility to care, accountability in provision of care, efficiency through maximizing utilization of resources, and optimal patient functioning.

(b) Clinical Use. Virtually all clients of mental health services can benefit from basic case management. Case management can be viewed along a continuum, with different levels of management used with different groups of patients, based on the needs of the patients and the intensity of services provided. Case management is a flexible, fluid process that changes as the needs of the patient change. So while a patient may require comprehensive or intensive case management in the beginning, stabilization of symptoms and enhanced functioning may lead to need for a less intense level.

(c) Basic Case Management. All case management includes some form of basic functions or activities. Basic case management incorporates many functions of routine clinical work, but is distinguished by its focus on coordination of services and continuity of care. Functions include:

1. Outreach and identification of appropriate clients;
2. Assessment of medical and psychosocial problems, spiritual injuries, and current strengths and weaknesses;
3. Treatment planning, where goals, specific interventions to achieve them, and methods to address outcome are specified;
4. Linkage with other providers and services as needed and coordination of care among them;
5. Follow-up and monitoring of outcome, with modifications of treatment plan as necessary; and
6. Advocacy for the client in obtaining access to services.

(d) Dimensions of Case Management. Case management is applied in various ways in mental health settings. It is tailored to meet the needs of specific client groups and service settings by varying the additional activities provided by case managers and the way in which case management is provided. Some dimensions that can be varied include focus, time frame, intensity (caseload), setting, availability, and frequency (Willenbring, 1991; 1994).

DIMENSION	**RANGE**
Focus	Narrow ---------- Comprehensive
Time Frame	Time limited ---------- Indefinite
Intensity (Caseload)	1:100 ----------1:10
Setting	Office ---------- Community
Availability	Office Hours ---------- 24 hours/day
	----------7 days/week
Frequency	Monthly ---------- Daily

NOTE: Ranges noted are for illustration purposes and not to be taken literally.

(e) Models of Case Management. Some common models used in mental health are listed as follows. This list is not exclusive; models should be individualized for specific settings and client populations (see subpar. 2b(4)(f)).

1. "Door to Door" Case Management
   a. Basic case management functions, usually in institutional settings.
   b. Time-limited, usually brief.
   c. Narrow focus on discharge or disposition planning.
   d. Usually facility-based, daily or non-daily contact.
   e. Target Clients. Those in transition from inpatient or partial hospital settings.
2. Primary Therapist
   a. Basic case management functions.
   b. Additional functions include crisis intervention and supportive psychotherapy.
   c. Usually comprehensive in form, indefinite, moderately intense (a ratio of 1:30-50) and office-based.
   d. Target Clients: Most mental health clients.
3. Medical Care Management
   a. Basic case management functions.
   b. Provided by physician or nurse.
   c. Normal focus on medication management and physical health.
   d. Usually less intensive (a ratio of 1:50-150), less frequent (monthly to quarterly), indefinite in length, and office-based, but could include home visits.
   e. Target Clients: All mental health patients.

NOTE: For the purposes of capturing workload, these first three are classified under standard case (care) management.

4. Intensive Case Management
   a. Basic case management functions.
   b. Additional functions include: crisis intervention, coping skills training, vocational rehabilitation, and community readjustment.
   c. Comprehensive, intensive (a ratio of less than 1:20), community-based, 24-hour-per-day availability, indefinite.
   d. Examples include: Assertive Community Treatment (ACT), Intensive Psychiatric Community Care (IPCC), and Strengths Model Community Case Management (Rosenheck, 1998; Rosenheck, 1998).
   e. Target Clients. Severe psychiatric illness, at risk for frequent or lengthy hospitalizations.
5. "Dual Disorder Case Management"
   a. Basic case management functions.
   b. Similar to intensive case management.
   c. Incorporates both mental health and addiction treatment foci.
   d. Target Clients: Patients with both severe and persistent mental illness and addictive disorders.
6. High-Risk Case Management
   a. Basic case management functions.
   b. Focused on reducing utilization and cost for high-risk patients.
   c. May be either narrow or broad in focus, time-limited (e.g., inpatient only) or indefinite.
   d. Emphasizes gatekeeper perspective more than facilitator of service access.

e. Target Clients. High utilizers, especially those using inappropriate or expensive services

(f) References

1. Corporate Strategy on Case Management. Department of Veterans Affairs, VHA Atlanta Network. VHA Headquarters, September 1997.
2. Laura Miller, Chair, VHA Work Group on Case Management. Draft Strategy on Case Management. Department of Veterans Affairs, VHA Headquarters, 1997.
3. Muesser KT, Bond GR, Drake RD. "Models of Community Care for Severe Mental Illness: A Review of Research on Case Management," Schizophrenia Bulletin. 1997.
4. Rosenheck RA, Neale M, Leaf P, Milstein R, Frisman L. "Multi-site Experimental Cost Study of Intensive Psychiatric Community Care," Schizophrenia Bulletin. 21; 129-140, 1995.
5. Rosenheck RA and Neale MS. "Cost effectiveness of Intensive Psychiatric Community Care for High Users of Inpatient Services," Archives of General Psychiatry. 55; 459-466, 1998.
6. Rosenheck RA and Neale MS. "Inter-site Variation in the Impact of Intensive Psychiatric Community Care on Hospital Use," American Journal of Orthopsychiatry. 68(2); 191-200, 1998.
7. Willenbring ML, Ridgely MS, Stinchfield R, Rose M. "Application of Case Management in Alcohol and Drug Dependence: Matching Techniques and Populations," Department of Health and Human Resources (DHHS) Publications. No. (ADM) 91-1766. Rockville, Maryland: Government Printing Office, 1991.
8. Willenbring ML. "Case Management Applications in Substance Abuse Disorders," Journal of Case Management. 1994.

Full text of the Mental Health Program Guide 1103.3 can be found at intranet web address ftp://vaww.mental health.med.va.gov/main/pg060799.doc

VA Connecticut Policy Statements

Healthcare System Policy No.11-86
Continuity of Care

Healthcare System Policy No. 118-8
Patients Receiving Home Intravenous (IV) Therapy

Healthcare System Policy No.118-13
Continuum of Home Health Care Services

Healthcare System Policy No. 11-91
Continuing Care and Case Management Program

Social Work Service, April 1996 - Service Memo No. 14
Social Work Affiliation and Liaison with Community Based Services

Social Work Service, April 1996 - Service Memo No. 18
Access to Community Resources

Social Work Service, April 1996 - Service Memo No. 19
Social Work and Continuing Care Policy

Department of Veterans Affairs
VA Connecticut Heath Care System

Healthcare System Policy No. 11-86

Continuity of Care

I. POLICY

Care is provided at the appropriate level based upon an ongoing assessment of the patient's needs. The assessment is followed through to the highest level possible while remaining within the parameters of each Patient's eligibility, accessibility, and availability to receive an array of services facilitated by the inter-disciplinary team. Each step of the continuum of care will be provided to the patient and family/significant others as appropriate. The patient's care is always coordinated among various healthcare professionals during all phases of care, which includes diagnosis, planning and treatment. The patient is referred, transferred or discharged to the appropriate level of care based on the assessment. If services are not provided at the medical center, the patient is referred to another health care provider. External utilization reviews conducted for the purpose of assessing appropriateness of admissions, continuation of the current level of care, and patient care or services which result in the denial of payment by a third party insurer will not influence decisions regarding the provision of ongoing or continuing services.

II. DEFINITIONS

A. Continuum of Care: a concept involving an integrated system of care that guides and matches the patient's needs with the appropriate level and type of medical, health or social services.

B. Continuity of Care: the integration and coordination of patient care over time through the Continuum of Care wherever the patient may reside.

C. Continuing Care: services needed by patients over an extended time, in various settings. spanning the illness-to-wellness continuum.

III. RESPONSIBILITY

A. Leadership at VA Connecticut Healthcare System is responsible for developing a strategic plan for the provision of health services based upon the assessed needs of the patients served.

B. Service Chiefs are responsible for supporting the strategic plan for providing services and allocating appropriate resources to the various programs throughout the Medical Center.

C. Individual clinicians are responsible for facilitating the patient's access to care, and for communicating the individual needs of each patient through the medical record and team members.

IV. PROCEDURE

A. Based upon the patients assessed needs, the patient is referred, transferred, or discharged to the appropriate level of care when appropriate. The patient will be referred to another healthcare provider if services cannot be provided at the Healthcare System.

B. Pre-entry phase: Patients may access care through any one of several access points. Care is coordinated for the transfer of patients both to and from other health care facilities. In the case of scheduled admissions, pertinent educational and instructional material is provided to the patient and family prior to admission. Patients not eligible for VA services are referred to a social worker as needed by eligibility or the evaluating clinician for referral to appropriate community agencies.

C. Entry phase: Standardized assessment procedures guide the patient's acceptance into various settings within the Healthcare System. Pertinent clinical information from patients being transferred from other health

care facilities is obtained prior to the actual transfer. Following an assessment, a decision regarding the appropriate level of care is made by the admitting physician. Patients are given the opportunity to execute Advanced Directives at the time of admission, if they have not already done so. Such directives also guide the admission of patients to specific levels of care. Information and instruction is provided regarding the planned care and treatment to be rendered.
D. Treatment phase: Individual reassessments are performed at regularly specified intervals related to the patient's course of treatment to determine the patient's response to treatment and/or when a significant change in the patients condition or diagnosis occurs. Interdisciplinary team meetings are held to review and discuss treatment and discharge plans and make necessary modifications based upon the assessed needs of the patient. To the maximum extent practicable all patient care is carried out with the full and informed consent of the patient.
E. Pre-exit phase: Discharge planning is initiated at the time of admission or prior to admission to determine continuing care services that will be needed when appropriate. The patient and family are educated about available and appropriate continuing care services and are involved in the decision making process.
F. Exit phase: When appropriate, continuing care services are arranged by the appropriate members of the team who convey all necessary medical and psychosocial information to the receiving program or agency. Patients are provided with a written copy of their discharge instructions that have been reviewed with the patient and family to ensure understanding of the instructions. Patients who need ongoing follow-up are enrolled into primary care and assigned a primary care provider and scheduled for a follow-up appointment.

V. REFERENCE
JCAHO Accreditation Manual for Hospitals. 1997 edition
Community Nursing Home M-5, Part II. Chapter 3
Outpatient Care-Fee. M-l. Part I. Chapter 18
Healthcare System Policy No. 11-39: "Integrated Patient Care Management"

VI. RESCISSIONS
None

VII. REVIEW SERVICE AND DATE
Nursing Service
Oct 08, 1999

Department of Veterans Affairs
VA Connecticut Healthcare Systems

Healthcare System Policy No. 118-8

Patients Receiving Home Intravenous (IV) Therapy

I. POLICY:
A. VA Connecticut Healthcare System will arrange home IV services with licensed, JCAHO accredited Home Health Care Agencies with home IV programs for patients who meet established criteria.
B. A Patient will meet the following criteria in order to be a candidate for home IV therapy:
1. No recent history of illegal drug abuse or medication non–compliance.
2. Reliable venous access or access device.
3. Safe home environment which includes electricity, hot running water and telephone, and assistance by family/significant other if needed.
4. Appropriate storage for medications and supplies in the home.
5. Available agency to provide both nursing coverage and IV medications.
6. Payment coverage identified (i.e., Fee Basis, Medicaid, Medicare, Private Insurance).
7. Initiation of at least one dose of medications in the hospital setting.
8. No other need for hospitalization.
9. A specific treating medical team and clinician agrees to be responsible for ongoing problems or questions and appropriate off-hours coverage identified.

II. DEFINITIONS:
Home IV therapy is defined as any therapy which requires continuous or intermittent peripheral or central vein access for administration of prescribed intravenous therapy.

III. RESPONSIBILITY:
A. A designated clinician is responsible for ordering and monitoring safety and efficacy. (Note: Infectious Disease can provide supervision of home IV antibiotic therapy for patients whose primary medical provider is unable to do so.)
B. The Continuing Care Nurse is responsible for coordinating home care services to ensure patient and/or significant other education has been initiated, to act as liaison between the patient and home care agency while the patient is receiving IV therapy in the home setting, determining source of payment and obtaining prior authorization and providing appropriate follow-up to assure patient compliance, satisfaction and appropriateness of treatment.
C. The Pharmacist is responsible for determining that the indicated drug therapy is suitable for home administration and for dispensing ordered supplies as needed.
D. Prosthetic service is responsible for providing non-pharmaceutical equipment if needed.

IV. PROCEDURE:
A. When home IV therapy is recommended by the physician in charge of the patient's treatment plan, the responsible physician will contact Continuing Care Services to provide an initial assessment of suitability for home IV care. The initial assessment should be completed within 24 hours of receipt of the initial consult. The assessment will include the veteran's/significant other's ability to assist and cooperate with and/or administer all aspects of the IV Treatment plan.
B. If the patient is a suitable candidate for home IV therapy:
1. The responsible physician will:

a. Document n the progress note (electronic progress note preferred) the treatment plan which includes diagnosis for which IV therapy is needed, the specific treatment recommended and the estimated duration of treatment.
b. Consults:
(1) Pharmacist to determine that drug therapy is appropriate for home administration.
(2) Appropriate subspecialty physician(s) if needed.
(3) Interventional Radiology for central line placement (or IV team for Percutaneous Intravenous Central Catheter (PICC) placement), if needed
c. Complete physician section of Home Health Referral Form to provide orders for home IV administration. Physician must designate, prior to discharge, the physician who will assume responsibility for providing follow-up once the patient is discharged. This will include lab results and making appropriate changes in the treatment plan if indicated.
d. Complete prescription 24 hours in advance of discharge, or as soon as the dosage is determined. Orders must be cosigned by physician responsible for home IV Treatment.
e. Complete Prosthetic request form 24 hours in advance of discharge, if the center must arrange for equipment, i.e., glucometer, hospital bed.
f. Assure post home infusion follow-up with appropriate physician.
2. The pharmacist, upon consult, will advise the physician of suitability of prescribed drug therapy for home administration, dispense supplies and replace IV medication to the pharmacy affiliated with the home IV therapy agency (when appropriate).
3. Continuing Care nurse will:
a. Determines patient suitability for home IV therapy including:
(1) Recommendation for venous access site, if not established.
(2) Consult to appropriate clinical subspecialty(s) if needed.
(3) Assessment of patient's/significant other's competence to cooperate with and/or administer all aspects of the IV home treatment plan, prior to referral to Home Health Agency.
(4) Determining appropriate payment source and obtaining approval for payments if indicated or preauthorization from private insurance.
b. Serve as consultant to treating physician from initiation of order for home IV therapy through discharge of patient.
c. Coordinate education of the patient/significant other with patient care manager on unit regarding care of venous access site and administration of IV therapy, with appropriate resources.
d. Offer patient a choice of three qualifying home health agencies that are certified in home infusion therapy.
e. Consult with Home Health Agency nursing specialists to provide pre and post-op teaching of central line care if needed as well as correct and safe administration of IV therapy.
f. Complete nursing section of Home Health Referral from (10-7108).
g. Consult with home health agency and the health care team to ensure that the patient has adequate and appropriate supplies and equipment for administration of IV therapy. This includes IV supplies for home use, prosthetic equipment, and needle disposal box.
h. Transmit per Facsimile the treatment plan on Form (10-7108) to selected home health nursing agency and third party payors, as needed.
i. Act as liaison to home care agencies to ensure safe and accurate administration of prescribed treatment regimen.
j. Obtain quality assessment and improvement data to assure home health care agencies and home IV companies meet Joint Commission standards.
k. Monitor home IV therapy program by periodic assessment of home health agencies and home IV companies to ensure positive patient outcomes.
4. When appropriate, Social Work Services will assist in determining payment source and perform a psychosocial assessment, on the Home Health Referral Form. The Social Worker will assist with applications for Medicare/Medicaid if indicated.

5. The physician on call for the appropriate service will be contacted during non-administrative hours at night and on weekends. Patients on chemotherapy will be covered by the oncology fellow on call.

V. REFERENCE:
Joint Commission Accreditation Standards for Home Health, Personal Care and Support Services. 1995.

VI. RESCISSIONS:
Nursing Service Policy CP-20
Medical Center Memorandum No. 11-32: "Intravenous (IV) Therapy in the Home"

VII. REVIEW SERVICE AND DATE:
Nursing Service, Oct. 4, 1998

Department of Veterans Affairs
VA Connecticut Healthcare Systems

Healthcare System Policy No. 118-13

Continuum of Home Health Care Services

I. POLICY:
VA Connecticut Healthcare System provides comprehensive, coordinated home care services for eligible veterans. Services are based on eligibility and individual patient needs, and include Home Based Primary Care (HBPC), referrals to community health agencies and Homemaker/Home Health Aide (H/HHA) services. Reevaluation of veterans health care needs occurs as needed to promote coordination and facilitate transition between various levels of care in a cost effective manner. Availability of services vary according to payment sources including Medicare, Medicaid, Fee Basis, Contract Nursing Home Program, alternate use of Contract Nursing Home funds and private insurance.

II. DEFINITIONS:
A. **Community Health Agencies:** Licensed, Medicare/Medicaid certified and accredited agencies selected in collaboration with the patient to provide a range of clinical services. Services offered are primarily nursing but often include physical therapy, speech therapy, occupational therapy, medical social worker and homemaker/home health aide. Services are usually provided for a limited time period.
B. **Fee Basis:** Authorizes payment for medically necessary, skilled home care services for eligible veterans on a fee for services basis. Services include nursing, physical therapy, occupational therapy, speech therapy and social work. Home health aid services are not covered except for eligible veterans in need of bowel and bladder care. Payment to the community home health agency providing care is paid by the VA Clinic of Jurisdiction at the Medicare rate. The cast of fee basis services may not exceed 75% of the local average contract nursing home rate.
C. **Homemaker/Home Health Aide Program:** A program that provides personal care in the home to veterans who would otherwise require nursing home care. Criteria include dependency in one or more activity of daily living (toileting, bathing, dressing, transferring, feeding) and/or dependency in 3 or more instrumental activities of daily living (food shopping, banking, light housekeeping, meal preparation, laundry).
D. **Hospice Home Care:** Available to eligible veterans through Medicare, Medicaid and some private insurance plan. Palliative services are provided and include comfort care, counseling, and supportive home care visits for terminally ill individuals and their families including skilled nursing, home health aides, social work and chaplain visits. Medications for the terminal condition, supplies and durable medical equipment are furnished. Bereavement counseling is provided to survivors.
E. **Home Based Primary Care:** A special program offered to functionally dependent, homebound patients for whom follow-up care at an outpatient clinic at VA Connecticut is not practical. Primary care is provided and is delivered by an interdisciplinary team. Medical care, nursing care and education, nutritional counseling and social work services are provided. Eligible veterans for HBPC include long term patients with multiple medical problems requiring prolonged intervention to maintain status and retard decline and patients with short term problems who need health services and home training prior to being managed in an outpatient clinic.
F. **Medicaid**: The Medicaid program provides for remedial, preventive, and long term medical care for income eligible aged, blind or disabled individuals, and families with children. Payment is made directly to health care providers, by the department, for services delivered to eligible individuals. Benefits include approved medical supplies and services, prescriptions, hospital, nursing home and home care.

G. **Medicare:** Provides payment for skilled home care services and pays for part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech therapy, medical social work services, and 80% of durable medical equipment To quality, the veteran must have at least one skilled need. Although Medicare home care is for the relatively short term post acute care, some chronically ill recipients can receive care for longer periods. Under the Medicare hospice benefit, Medicare pays for home care and a variety of services (including custodial care, homemaker services and counseling) not otherwise covered under Medicare Private
H. **Health Insurance:** Insurance policies held by individual veterans that offer covered services with frequency and duration of services frequently are more restrictive. Continuing Care and Community Health staff who make referral and provide case management investigate limits of coverage for fee for services and managed care plan.

III. RESPONSIBILITY:
Continuing Care and Case Management staff are responsible for the coordination of care. Identified primary providers and attending physicians are responsible for medical management and plan of care, and will be responsive to veterans problems and needs identified by agency personnel. Care Management staff, Primary Provider, and Quality Management Service are responsible for monitoring the quality of care delivered in the community in a collaborative manner.

IV. PROCEDURE:
A. Continuing Care and Case Management staff will coordinate and review home care referrals to provide VA Connecticut providers and health care staff an access point to initiate planning for the most appropriate in home services for a patient Assessment of home health care needs for the patient will be made so that an appropriate management plan can be developed.
B. All patients referred to community agencies will have an identified primary care provider so that agency personnel will have access to medical direction. Continuing Care and Case Management staff are the liaison and communicator between the agencies and VA Connecticut Healthcare System for availability and access to VA programs and services.
C. Quality of services rendered by community agencies will be overseen by providers responsible for plan of care and case management staff at the VA Connecticut Healthcare System. Licensed Medicare/Medicaid certified and/or accredited agencies will be selected. Agencies which are not accredited by JCAHO will furnish evidence of the quality of their services to the Program Director, Continuing Care and Case Management A sample of patients using community services should be visited to assess the quality of care provided as well as patient satisfaction with that care. All complaints from veterans beneficiaries concerning the services provided by a community agency will be promptly explored.

V. REFERENCE:
VHA Directive 10-95-018 Feb. 15, 1995
VHA Directive 10-94-028 April 12, 1994
VHA Vision for Change
M-l, Part 1, Chapter 18, Change 3 July 20, 1995

VI. RESCISSIONS:
None.

VII. REVIEW AND SERVICE DATE:
Nursing Service.
Feb 14, 1999

Department of Veterans Affairs
VA Connecticut Healthcare Systems

Healthcare System Policy No. 11-91

Continuing Care and Case Management Program

I. POLICY

It is the policy of this medical center to provide a coordinated approach to patient care for veterans; especially those suffering from catastrophic and/or costly illness or those assessed to be at high risk for decompensation. Case managers in collaboration with the interdisciplinary team will coordinate care management in accordance with *VA Care* strategic initiative. The objectives of the Continuing Care and Case Management Program are:

A. To systematically and efficiently manage a patient's access to, progression through, and transition from one level of care to another.

B. To provide objective information to patients, family members and staff as needed.

C. To facilitate achievement of patient care goals warranting hospitalization, and discharge within an appropriate length of stay. (LOS).

D. To maximize efficiency in th utilization of health care resources, reduce unnecessary costs and maximize revenue through MCCF.

E. To work collaboratively with the patient, family/significant other, and members of the healthcare team to implement a plan of care across the continuum to meet each patient's individual needs and improve/promote patient satisfaction.

II. DEFINITION:

Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. The basic structure of the Case Management model is the Case Management Team, comprised of an admissions officer, Surgical Case Coordinator, case managers assigned to each Primary Care Firm, Geriatrics and Extended Care, Psychiatry, Specialty Services, and designated physician for medical review as needed. Case managers follow patients through the continuum of care and coordinate services as appropriate with VA providers and/or community based providers, and inpatient Patient Care Coordinators and the interdisciplinary team on acute medical and surgical units.

III. RESPONSIBILITIES:

A. AD/Patient Care Services has overall responsibility for the Case Management Program.

B. The Program Director, Continuing Care and Case Management is responsible for the day-to-day supervision and oversight of the Case Management Program.

C. Patient Care Coordinators on acute medical and surgical units are responsible for:

1. Coordination of inpatient care from admission to discharge and ensuring appropriate bed status is documented in the medical record.
2. Leading Interdisciplinary Patient Care Meetings.
3. Coordination of transitional planning and referrals for continuing care.
4. Identifying patients for case management.
5. Assuring identification of patient needs in the care plan and working with staff to assure completion.
6. Participation in and facilitation of organizational performance and improvement.
7. Patient advocacy.

D. Case Managers are specially rained registered nurses and social workers responsible for case management of the patient (as defined above) across the continuum of care. Specific responsibilities include:
   1. Reviewing pre-admission and coordinating with MCCF nurses for pre-certification as appropriate.
   2. Facilitating and supporting care goals within an appropriate length of stay based on established standards of care and practices in collaboration with the Interdisciplinary Team.
   3. Implementing the transition plan and assuring referrals are sent and received by community agency for continuing care.
   4. Assuring appropriate payor source has been identified for continuing care needs, that all paperwork is completed and that referral is to Medicare/Medicaid certified, JCAHO accredited community agency of patient's choice.
   5. Following patients identified for case management based on established criteria (Attachment A) and following for short or long term case management. Specific goals will be identified and a plan of care will be established within one working day. When goals are met, patients will be discharged from case management.
   6. Participating in and facilitation of organizational performance improvement.
   7. Patient advocacy.

E. Case Coordinators are providers, primary and/or collaborative, of direct psychiatric services provided to veterans identified as high risk/high resource users. Case Coordinators are not case managers and will refer patients for case management using established criteria.

F. Quality Management is responsible for completing admission and continued stay reviews. The reviewer works collaboratively with and matrixes with the Continuing Care & Case Management program by communicating outcomes of reviews each administrative day with the Patient Care Coordinator or designee.

IV. PROCEDURES:

A. The physician, based on clinical needs of the patient, identifies the appropriate level of care needed and collaborates with members of the interdisciplinary team as appropriate. No patient will be denied care based solely on utilization review criteria.

B. When a patient is identified for case management, the case manager, in conjunction with other members of the interdisciplinary patient care team, will identify immediate, short-term, and ongoing patient care needs, and determine how those needs can best be met.

C. Patients will be admitted and discharged from case management based on established criteria.

V. REFERENCES:

A. Care Management: A VA Perspective, Rhode Island, 5/31/98

B. Care Management in VA: Resources and Reference Materials for VA Case Manager, 1/99

C. Office of Primary & Ambulatory Care (Exec. Summary Managed Care Consensus Conference) VA Wide Goals & Objectives to Accomplish VHA's Managed Care Vision and Strategy, 2/20/98

D. Process for Determining Case Management Employment/Definition of Case Management, Commission for Case Manager Certification, 9/96

VI. RESCISSIONS:

None.

VII. REVIEW SERVICE AND DATE:

Associate Director/Patient Care

Attachment A
Screen for Case Management

Factors to be considered in identifying patients for admission to short or long term Case management:

1) Patients with one or more ADL dependencies and dependence in three or more IADLs.
2) No significant informal support system, i.e., lives alone or with someone unable to provide care.
3) Repeat admissions, i.e., three or more hospitalizations within a three month period, re-admitted within 1 month with the same diagnosis and /or three or more unscheduled visits within a six month period.
4) Unplanned readmission within a month of discharge.
5) Irregular discharge within the past 6 months.
6) Homeless, i.e., no identifiable address.
7) Patient in a special population, i.e., HIV, SCI, PTSD, POW, TBI, Persian Gulf War Veteran, Victim of Abuse/Neglect (elder/spousal), Victim of Violent Act.
8) Currently involved with a community resource agency (i.e., VNA, HBPC, etc.)
9) Admitted from a long-term Care facility (VA Nursing Home Care Facility, VA Contract Nursing Home).
10) Competency issues, i.e., comatose, semi-comatose, organic thought disorder, psychiatric/substance abuse disorders, disorientation or confusion that place patient at risk for decompensation.
11) Dressing changes, wound care, ostomy care.
12) Equipment and supply needs, including Durable Medical Equipment (DME).
13) Special teaching needs.
14) Multiple trauma.
15) Fractured hip and/or history of frequent falls (with or without injury).
16) Patients requiring continuing care under Fee Basis, Contract Nursing Home Program, ADC and H/HHA Program, or self-pay.
17) Terminal or pre-terminal status (prognosis of 6 months or less life expectancy).
18) Requires rehabilitative services (PT, OT, ST) coordination and/or pre-authorization with third party payor.
19) Complexity of care needs including Foley catheter care, G-tube, Supra-Public, Trach, ventilator support.
20) Transfers that require coordination and/or pre-authorization with third party payor or VA Contract Nursing Home Program and/or VA Fee Basis Care.
21) Legally blind and/or profound hearing impairment.
22) Transportation difficulties.
23) Progressive neurological, pulmonary, cardiovascular, cancer or renal disease with resulting impairments.

VA Connecticut Healthcare System

Social Work Service
April 1996
Service Memo No. 14

Social Work Affiliation and Liaison with Community Based Services

I. PURPOSE:
To establish policy for Social Work liaison with community based services in enhancing the Veteran's adjustment to and rehabilitation in the Community.

II. POLICY:
The Social Work Service, along with other members of the patient care team, will routinely participate in community based services planning, development, and liaison to reinforce the Veterans' readjustment to the community and the continuity of his rehabilitation beyond hospitalization. In addition, this focus will emphasize the goal of assisting the Veteran in achieving adjustment in the Community through the least restrictive means of care possible, i.e., : Community based treatment services and outreach efforts.

III. RESPONSIBILITY:
The Chief, Social Work Service or his designee(s) will be responsible for defining the policies and procedures for appropriate utilization of Community resources on the Veteran's behalf.

IV. PROCEDURE:
Social Work will participate in Community planning of Veteran's services in conjunction with the Medical Center VAVS and member service organizations in identifying gaps in program development that address the changing needs of the Veteran population Resource development will be pursued through participation and collaboration with service organizations, community and state agencies to fulfill the goals of a social, vocational, and physical adjustment, and rehabilitation for Veterans in the Community. In addition, Social Workers will be knowledgeable of existing services in the Community to assist all Veterans; in adjustment to non-hospital based service training and information sharing at Social Work Administrative and Staff Development meetings. Social Workers will actively coordinate service delivery with appropriate agencies to provide the best possible care for those veterans released from In Patient Care, as well as those seeking Primary outpatient care.

V. REFERENCE:
DM&S Supplement, M-2, Part XIII Service Memo No.

VI. RESCISSIONS:
None.

VII. REVIEW DATE:
April, 1999

VA Connecticut Healthcare System

Social Work Service
April 1996
Service Memo No. 18

Access to Community Resources

I. POLICY:
Patient will be informed of services appropriate to promote smooth transitions through discharge or transfer from a program, unit, or service of the organization. During the assessment process, patient's educational needs and expectations relative to community resources will be. Addressed.

II. DEFINITION:
None.

III. RESPONSIBILITY:
The interdisciplinary care team members, including the physician or other licensed independent practitioner(s) primarily responsible for the patients, social work, nursing, and other appropriate staff are responsible for providing patient/family education regarding access to community resources.

IV. PROCEDURE:
The interdisciplinary care team members, including the physician or other licensed independent practitioner(s) primarily responsible for the patients, social work, nursing, and other appropriate staff are responsible for providing patient/family education regarding access to community resources.

V. REFERENCE:
JCAHO Accreditation Manual for Hospitals, 1995

VI. RESCISSION:
None.

VII. REVIEW SERVICE AND DATE:
Social Work Service
April 1999

VA Connecticut Healthcare System

Social Work Service
April 1996
Service Memo No. 19

Social Work and Continuing Care Policy

I. POLICY: Social Work Service will provide as part of a continuum of care an integrated system of settings, services and care levels. Social Work Service will provide an assessment of patients need for continuing care and when clinically indicated will provide coordination of care among units. Social Work Service will provide continuing care from assessment through treatment and follow-up.

II. DEFINITION:
Continuing Care: Care provided over an extended time, in various settings, between West Haven and Newington Campus, spanning the illness to wellness continuum.

Transfer: The formal shifting of responsibility for the care of a patient within the same organization.

Coordination of Care: Integration of the components of care

III. RESPONSIBILITY:
A. Transfer within the hospital: The social worker on the unit initiating transfer will be responsible for contacting the social worker on the receiving unit. Social work responsibility remains with the unit social worker.
B. Inpatient discharge to outpatient: The inpatient social worker is responsible for notifying (and or identifying) the outpatient social worker upon patients admission and discharge.
C. Outpatient unit/outpatient unit: When clinically appropriate, the social worker of unit initiating transfer will contact social worker of receiving unit to ensure coordination of care.

IV. PROCEDURES:
The social worker initiating contact with social worker for coordination or continuum care will document in the official chart transfer, discharge, and or social work intervention. Receiving unit Social Worker will document any follow-up action taken.

V. REFERENCE:
JCAHO standards, Continuum of Care 1995, Section 1 p. 23-15

VI. RESCISSIONS: None.

VII. REVIEW AND SERVICE DATE:
Social Work Service, April 1999

VA Medical Center, Albuquerque, New Mexico Policy Statements

Memorandum 122-4 - April 3, 1998
Care Management for At-Risk Patients

Memorandum 122-20, June 11, 1998
Care Management in Primary Care Programs

VA Medical Center
Albuquerque, New Mexico

Memorandum 122-4
April 3, 1998
122/JEM

CARE MANAGEMENT PROGRAM FOR AT-RISK PATIENTS

1. **Policy:** Social Work Service provides care management services (formerly known as "case management") for veterans identified as high risk or at-risk in order to enhance continuity of care and reduce admissions and lengths of stay for such veterans.

2. **Responsibility:** Social Work Service will provide interdisciplinary team members with criteria to assist in identifying high risk/at-risk patients. Social Work Service will assign social workers as care managers for patients meeting the criteria.

3. **Procedures:**
   a. Definition of High Risk/At-Risk: Veterans meeting one or more of the following criteria will be considered high risk/at-risk:
      (1) Homeless with no apparent fixed or temporary shelter or support systems
      (2) Unable to care for self (physically, emotionally or mentally)
      (3) Suspected abuse, neglect or exploitation or being followed by New Mexico Adult Protective Services
      (4) Multiple unscheduled admissions or visits to the Emergency Department within the last year
      (5) Incompetent or in need of payee/guardian
   b. Definition of Care Management Services: A system to provide for planned and systematic use of VA and community services which requires a focus on the veteran's need for services and conservation of Medical Center resources. It includes continuity of care from the point of contact through admissions, discharges, and follow-up in ambulatory care and in the community and may involve home visits.
   c. Referrals: Although social workers will conduct case finding, interdisciplinary team members are encouraged to help identify high risk/at-risk patients. Referrals may be made verbally, but should be formalized with an electronic consultation.
      (1) Social workers are assigned to all primary care programs and provide psychosocial care management services for primary care patients identified as high risk/at risk.
      (2) Medical, surgical and geriatric inpatients identified by the treatment team as high risk/at risk should be discussed at interdisciplinary treatment/discharge planning meetings and referred to the team social worker. On inpatient Psychiatry, the CATS team member attending daily Kardex rounds will notify the appropriate Mental Health program for care management services.

(3) Medical outpatients enrolled in primary care who meet the high risk/at risk criteria should be referred to the social worker care manager assigned to that team. Those not enrolled in primary care should be referred to Social Work Service (122) via electronic consults. Mental Health outpatients not enrolled in Psychiatric Primary Care should be referred to the Consultation and Triage Services (CATS) team.

(4) Veterans identified as high risk/at-risk who live outside of the Albuquerque metropolitan area should be referred to Social Work Service (122) via electronic consults for care management in the community through social workers in the community-based clinics and in the Native American Outreach Program.

d. Assessment: Upon referral, social workers will conduct a comprehensive psychosocial assessment, identifying treatment goals and outlining services to be provided. Assessments, reassessments, treatment plans and notes will be placed in the medical record. If the assessment identifies that the veteran can benefit more from medical care management services, the social worker will consult with the primary care nurse care manager.

e. Case Review: Social workers will periodically review patients in their care management caseload to determine whether care management services are still indicated and will so annotate treatment planning forms and medical record progress notes.

f. Hours Coverage: Social worker care managers are available Monday through Friday from 8:00 am till 4:30 pm. The Emergency Department social worker is available until 6:00 pm Monday through Friday. If a veteran requires after hours care management services, the Administrative Officer of the Day (AOD) has access to the Social Work Service On-Call Program schedule and can contact the on-call social worker.

4. References: M-2, Part XII, Chapter 3; dated February 10, 1992.

5. Rescission: Memorandum 122-4, August 9, 1996, Case Management of At Risk Patients.

6. Expiration Date: April 2001

Signed MCM in D/FMO File.
N.E. BROWNE
Medical Center Director
Distribution: "A"

VA Medical Center
Albuquerque, New Mexico

Memorandum 122-20
June 11, 1998
122/JEM

CARE MANAGEMENT IN PRIMARY CARE PROGRAMS

1. **Policy:** VA Care Management is designed to provide patient-centered, high quality health care. Primary care teams are required to provide care management at the appropriate level, so that all veterans have access to a Social Worker and nurse care manager.

2. **Responsibility:** The Chiefs of Social Work and Nursing Services are responsible for assuring that care management services are provided to veterans assigned to primary care panels.

3. **Definition:** VA Care Management is that aspect of primary care that coordinates care across all settings. It is patient-centered rather than disease-specific.

4. **Procedures:**
   a. VA care managers are responsible for screening and providing the appropriate intensity or level of care management for a panel of patients. The extent of care management required by any one patient can vary over time. Not all patients need care management. VA care managers coordinate care for all diseases and all episodes of illness by integrating an assessment of living conditions, family dynamics and cultural background into the patient's plan of care.

   b. Care managers at the Medical Center are typically social workers and nurses. However, other members of the primary care team may serve as care managers when appropriate. Social Work and nurse care managers have care management duties outlined in position descriptions and functional statements.

   c. Social Work Service will assign care managers to:

      (1) GMED-A, GMED-B, GMED-T, PRIME, GMED-WH, GMED-G, Hematology/Oncology, Renal, Cardiology, Infectious Disease, Gastroenterology, and Rheumatology;

      (2) The Community-Based Clinics in Artesia, Farmington, Gallup and Silver City;

      (3) Primary care patients in Spinal Cord Injury, Neurology, and Rehabilitation;

      (4) Psychiatry Primary Care

      (5) Surgery to follow patients in Surgery clinics, Ambulatory Surgery Unit and those admitted for inpatient surgical procedures.

   d. The Social Work care manager will be available to all veterans assigned to his/her primary care team and will follow patients across episodes of care. Social Work care managers will coordinate services with primary care staff and inpatient staff on treatment and discharge planning. After hours Administrative Officer of the Day.

   e. Nursing Service will assign nurse care managers to GMED-A, GMED-B, GMED-T, PRIME, GMED-WH, AND GMED-G.

   f. The Social Work and nurse care managers assigned to primary care programs will work together as a care management team to assure veterans receive comprehensive care across the continuum of care and that biopychosocial needs are addressed. Typically, veterans in need of medical care management services will be followed by a nurse and those in need of psychosocial services will be followed by a social worker.

5. **Referrals:** Primary care team members should make referrals for care management services directly to the Social Work or nurse care manager assigned to that primary care team. At treatment planning meetings, primary care team members should identify veterans in need of care management services. In particular, they should identify those veterans who meet the high risk criteria for psychosocial and medical care management.

   a. Psychosocial high risk include:

      (1) Homeless with no apparent fixed or temporary shelter or support system;

      (2) Unable to care for self physically, emotionally or mentally;

      (3) Suspected abuse, neglect or exploitation;

      (4) Multiple unscheduled admissions or visits to the Emergency Room;

      (5) Incompetent or in need of payee/guardian;

      (6) Veterans whose admissions are considered "social admissions";

      (7) Actively abusing substances.

   b. Medical high risk criteria include:

      (1) Medially complex patients needing disease management;

      (2) Knowledge deficit related to health issues;

      (3) Non-compliance with medical regime;

      (4) Newly diagnosed catastrophic illness resulting in major lifestyle changes;

      (5) Dementia or cognitive impairment;

      (6) Self-care deficit requiring home care or community placement;

      (7) Chronic pain patients requiring contracts for management.

6. **References:** M-2, Part XII, Chapter 3, February 10, 1992; Windows to Primary Care: Social Work Support for Primary Care, September 1, 1994; Social Work Service Practice Guidelines, October 1994; Case Management Outcomes & Measures: A Social Work Source Book, September 1997; Medical Center Memorandum 122-4, April 3, 1998; Care Management for At-Risk Patients.

7. **Recission None.**

8. **Expiration Date: This Memoranda will expire June 30, 2001.**

Signed MCM in D/FMO File.
N.E. BROWNE
Medical Center Director
Distribution "A"

SCREENING AND ASSESSMENT

SUGGESTED METHODS FOR SCREENING FOR CASE FINDING OF PATIENTS WHO NEED CARE MANAGEMENT

- A PTF data base search for patients with "x" (perhaps three or more) acute hospital admissions over a given FY. (This would perhaps indicate patients of a clinically complex nature, with multiple disease processes, that would or may indicate closer, more integrated case management functions.)

- A VistA sort for patients seen in five or more OPT clinics (other than primary care) in a given FY (due to frequency of service & consumption of specialty resources other than primary care). A VistA sort for patients seen in primary care more than four times per year, as that appears to be the baseline standard for primary care patients.

- Look closely at patients who are provided OPT Fee Basis care (often overlooked & need to be managed at the facility level by a Care Manager).

- A VistA sort of the Rx data base for patients having six or more prescribed medications? (This may be another opportunity to identify patients of a clinically complex nature, with multiple disease processes, that would or may indicate closer, more integrated Care Management functions.)

- All patients administratively enrolled in Geriatric Evaluation Management (GEM) programs (ID the aged patient).

The Department of Veterans Affairs
Employee Education System
Presents

CARE MANAGEMENT IN VA:

An Assessment Tool for Care Managers

This is a Veterans Health Administration product, sponsored and produced by the Employee Education System, in cooperation with the Office of Patient Care Services, Headquarters.

September 1999

Table of Contents

Acknowledgments

This assessment tool for care managers was designed to serve as the critical link between the patient and the treatment plan. This project was initiated by the Care Management Task Force of EES and carried out by a sub group of that task force.

Sincere appreciation is extended to several individuals who made this work a reality. The members of the EES Care Management Task Force who contributed their valuable knowledge, generous collegiality and time to this project include:

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Special thanks are extended to **Linda Truman**, BA, Program Development Manager, EES for her expertise in designing and producing the final product.

Individuals on the Care Management Task Force of EES were especially helpful in critiquing and evaluating the initial draft of this assessment tool. Their feedback helped in final adjustments to the original draft.

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Introduction

Assessment is the process of collecting, analyzing and integrating information about a patient's strengths, weaknesses and problems. The resulting profile of the patient's needs and resources can be used as the basis of a comprehensive care management plan.

An assessment is a multi-dimensional process since it focuses not only on the medical aspects but also on the psychological, socioeconomic and cultural facets of a patient. In addition, the caregiver's physical, mental and emotional abilities to support the patient at home are assessed. Relevant information is gathered from the patient, his/her family, treatment providers, caregivers, employers, health records, educational/military records, funding sources, etc. Information is gathered by telephone, through chart review, medical records review and interviews with significant individuals.

The assessment process begins after the initial screening process is used to identify individuals in need of care management. Assessment is a continuous process of gathering information used to develop a plan as well as to monitor and evaluate the plan's effectiveness. For this reason, the assessment phase of care management is considered to be an "on going" process. Assessments must be thorough and systematic so that a patient's problems can be identified and the care manager in conjunction with the treatment team can develop effective solutions.

The enclosed assessment tool is offered to VA Care Managers to use as a guide to assessing patients' needs. Use your own judgement as to which questions are appropriate to ask each individual patient.

Assessment Domains

During assessment, the care manager identifies problems the patient is having in the following domains:

- ***Personal Data.*** This general information includes demographics, occupation, education, religion, and other relevant background information.

- ***Health Status.*** Information is gathered in this domain by questioning the patient about his or her own perception of health, medical history, current symptoms and medications, and sensory abilities (e.g. vision, hearing,etc.)

- ***Cultural Sensitivity.*** The patient's unique cultural behavior is determined by assessing his/her communication abilities, spatial comfort, social organization, and environmental controls.

- **Emotional Status.** Questions in this area focus on the patient's affective feelings, social functioning and behavior.

- ***Cognitive Function.*** Screening tests are used to measure the client's memory and judgment abilities.

- ***Functional Status.*** Functional assessment scales help identify the patient's ability to perform personal care and household management.

- ***Home Environment.*** The patient's current home is evaluated for its current condition, hazards, and potential modifications.

- **Patient Support System.** The patient's living arrangements as well as his support network are determined.

- ***Caregiver Support System.*** An evaluation of the strength of a patient's caregiver network is done. The current level of assistance the individual receives can be determined by interviewing primary caregiver(s).

- ***Spiritual Status.*** Information is gathered about the patient's personal spirituality, ritualized practices and restrictions, integration and involvement with others in a spiritual community, implications for medical care and end-of-life planning.

- ***Financial Status.*** Information is collected regarding the patient's expenses, income and assets, and entitlement eligibility.

Based on the information obtained in these areas, the care manager can explore specific areas in greater depth. After analyzing the collected data and defining specific strengths and problems, the care manager is ready to offer recommendations about what type of assistance the patient might need. A Care Management Needs Planning Sheet is included to help you plan appropriate interventions.

Assessment Tool for Care Management

This assessment tool should be used in conjunction with a thorough medical record review. Both the questions and problem labels identified in this tool are not intended to be a comprehensive listing. They are often the lead questions to a series of probing questions that will vary with each patient. The problem labels illustrate the more common problems that may exist and are suggestive in nature.

PERSONAL DATA

NAME: _____ SEX: M/F AGE: _____ DOB: _____

ADDRESS: _____

PHONE: _____ MARITAL STATUS: S M W D # YEARS: _____

ETHNICITY: _____ RELIGIOUS AFFILIATION: _____

PLACE OF BIRTH: _____ EDUCATIONAL LEVEL: _____

OCCUPATION: _____ YEARS RETIRED: _____ WHY: _____

OF CHILDREN: _____ # OF CHILDREN INVOLVED IN CARE: _____

PRIMARY CARE PHYSICIAN: _____

SERVICE CONNECTION STATUS: _____

(%): (CONDITION):

WEIGHT: _____ HEIGHT: _____

UNUSUAL VISIBLE CHARACTERISTICS:

Domain: Cultural Sensitivity

Communication	*Suggested Questions*	*Comments*
Language	What is your native tongue?	
	Can you understand me or would you like an interpreter?	
Touch	How do you feel when a loved one touches you while talking with you?	
	A stranger?	
	Do you touch others when you speak with them?	
Nonverbal	When asked a question, do you usually respond (in words, body movement, or both)?	
Literacy Level	What do you like to read?	
	How do you like to receive information? (Assess literacy levels for appropriate educational material).	

Possible Problem Labels	*Identified Problems*
Inability to understand others.	
Inability to express concerns and ideas.	
Doesn't understand English.	
Can't read or reads at low literacy level.	
Other problems:	

Space		
Comfort/Distance	When you talk with family members, how close do you stand?	
	With coworkers/ acquaintances? Strangers?	
	Are you comfortable with the distance between us now?	

Domain: Cultural Sensitivity

	Possible Problem Labels	*Identified Problems*
	Uncomfortable with distance and touching practices accepted in the community.	
	Other Problems:	

Social Organization	*Suggested Questions*	*Comments*
Family Role/ Function	What is your role (mother, father, etc.) in your family? What is your function (what do you do?)	
	What is your relationship with siblings/parents?	
	Who is the relative that you have the most contact with?	
	How many relatives do you see or hear from at least once a month?	
Children	How many children do you have?	
	Where do they live?	
	How often do you see them?	
Friends	Do you have any close friends?	
	How often do you see your friends?	
	Tell me about the friend that you have the most contact with? How do you support each other?	
	Does any relative/friend rely on you to do something for them each day?	
Activities	Do you work? Doing what?	
	What does work mean to you?	
	What do you like to do in your free time?	

Domain: Cultural Sensitivity

	Possible Problem Labels	*Identified Problems*
	Unstable home situation.	
	Interpersonal relationship problem.	
	Lacks support system. / Lives alone.	
	No one to assist with critical decisions.	
	No outside stimulation. / Activity intolerance.	
	Other problems:	

Environmental Control	*Suggested Questions*	*Comments*
Locus of Control	Do you think you can do things to change what is happening in your life or do you think it is all luck or chance that controls your fate?	
Definitions of Health/Illness	What is it like to be in good health? Poor health?	
	When you are ill, what do you have to do to recover?	
	Do you use home remedies? What works for you?	

	Possible Problem Labels	*Identified Problems*
	Self-concept problem. / Not self-motivated.	
	Relies extensively on home remedies.	
	Limited concept of wellness.	
	Relies exclusively on others to make	
	healthcare decisions.	
	Other problems:	

Domain: Health Status

	Suggested Questions	*Comments*
Medical History	Tell me about your major health problems and what is troubling to you now?	
	How often do you feel sick because of these problems?	
	Have you been treated overnight in the hospital for these problems?	
	Possible Problem Labels	
	Unrealistic expectations.	
	High medical risk.	
	Medically unstable.	
	Other problems:	
Medication History	Are you taking any prescription, over the counter or herbal medications and how often you take them?	

Drug	Dose/Frequency	Side Effects

Domain: Health Status

	Suggested Questions	*Comments*
	Are you taking these drugs the way your doctor wants you to take them?	
	Do you notice any change since you started taking the medications?	
	Is there someone that helps you take your medications?	
	How do you remind yourself to take medications at a specific time?	
	Are you up to date on your immunizations?	

	Possible Problem Labels	*Identified Problems*
	Polypharmacy.	
	Deviation from prescribed dose/schedule.	
	Failure to obtain refills appropriately.	
	Demonstrates drug effects.	
	Inadequate system for taking medications.	
	Fails to obtain immunization.	

Care Access	What is the name of your PCP?	
	How often do you see your PCP?	
	Are you being cared for by any physician outside the VHA?	
	What do you do if you get sick before your scheduled appointment?	
	If you have a clinic appointment at 2PM, what time do you arrive?	
	How many times were you treated in the ER in the past year?	
	How many times were you hospitalized in the past year?	

Domain: Health Status

	Possible Problem Labels	*Identified Problems*
	Lack PCP.	
	Not keeping or not scheduling appointments.	
	Overuses/underuses ER.	
	Multiple admissions.	
	Lacks transportation to and from appointments.	
Sensory Problems	Do you have problems seeing? (If yes: Do problems seeing make it hard to follow doctor's instructions?)	
	Do you have hearing problems? (If yes: Do problems hearing make it hard to follow doctor's instructions?)	
	Possible Problem Labels	***Identified Problems***
	Visually impaired. / Hearing impaired.	
Nutrition	Has your weight changed in the last 6 months? If yes:	
	a. Has there been a weight loss?	
	Have you been trying to lose weight?	
	How much weight have you lost?	
	b. Has there been a weight gain?	
	Have you been trying to gain weight?	
	How much weight have you gained?	
	How many meals a day do you eat?	
	Do you prepare your own meals, or do you have meals delivered to your home?	
	Do you have enough money to buy the food you need?	
	Do you have a tooth or mouth problem that makes it difficult for you to eat?	

Domain: Health Status

What foods do you or your family like to eat? What do you avoid eating? _____

Do any of your medical conditions effect the kinds and amounts of food you eat? _____

How many fruits and vegetables do you eat in a day? _____

Possible Problem Labels	***Identified Problems***
Malnourished/ dehydrated.	_____
Obesity/ fluid retention.	_____
Inadequate finances.	_____
Dental process.	_____
Unbalanced diet.	_____
Unexplained/ progressive weight loss.	_____

Sleep Patterns

How many hours do you sleep at night? _____

Is your sleep uninterrupted or do you waken many times? _____

Do you take naps during the day? How often? How long? _____

Do you feel tired after you sleep? _____

Possible Problem Labels	***Identified Problems***
Sleep deprivation.	_____
Lack of focus.	_____
Lack of energy.	_____
Malaise.	_____
Depression.	_____

Domain: Emotional Status

Suggested Questions	*Comments*
Have you in the past or are you presently receiving mental health treatment or counseling?	
Initial Depression screen:	
• Are you basically satisfied with your life?	
• Have you dropped many of your activities and interests?	
• Do you feel that your life is empty?	
• Do you feel happy most of the time?	
• Do you feel helpless?	
• Do you often feel anxious or on edge?	
For greater depth use screens for Mood Disorders from The VHA Clinical Guideline for Major Depressive Disorder (MDD); MDD with PTSD; MDD with SA (see pages 18 and 19)	
Have you ever been physically, verbally, or sexually abused?	
Are you currently being physically, verbally or sexually abused?	
Do you feel you are neglected or exploited by an adult child or others?	
Do you drink alcohol?	
How much do you drink a day?	
CAGE Questions:	
Have you ever felt you should cut down on your drinking?	
Have people annoyed you by criticizing your drinking?	
Have you ever felt bad or guilty about drinking?	
Have you ever taken a drink first thing in the morning (Eye opener) to steady your nerves or get rid of a hangover?	
NOTE: If the CAGE score is 2, there is clinical significance.	

Domain: Emotional Status

Do you take any illegal street drugs? _____

How often do you use these drugs? _____

Possible Problem Labels	***Identified Problems***
Sadness.	_____
Hopeless.	_____
Worthless.	_____
Fear. Coping difficulty.	_____
Restless/combative.	_____
Flat affect.	_____
Agitated.	_____
Difficulty managing stress.	_____
Expresses wish to die.	_____
Somatic complaints.	_____
Substance Abuse.	_____
Depression.	_____

I. Mood Disorder Screen* for Under Age 60 Population

A. How much of the time during the past week did you feel depressed?
If 'LESS THAN ONE DAY', THEN SKIP TO END (NEGATIVE SCREEN.
If 'ONE OR MORE DAYS', then go on to question B.

B. In the past year, have you had two consecutive weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?
If 'YES'. Skip to end (positive screen).
If 'NO', ask question C.

C. Have you had two years or more in your life when you felt depressed or sad most days even if you felt okay sometimes?
If 'YES', ask question D.
If 'NO', skip to end (negative screen).

D. Have you felt depressed or sad much the time in the past year?
If 'YES', screen is positive.
If 'NO', screen is negative

Positive Screen: The patient must indicate 'one or more days' on question A, and 'yes' on either question B or D (or both).

II. Geriatric Screening Instrument* for Depression in Patients Age 60 Years Old or Older

For each of the following please indicate how often you felt that way **DURING THE PAST WEEK** using the following ratings:

Rating for questions 1, 2, 3, and 4 only	**Score**
Rarely or none of the time (less than one day)	0
Some or a little of the time (1 to 2 days)	1
Moderately or much of the time (3 to 4 days)	2
Most or almost all the time (5 to 7 days)	3
1. I felt that I could not shake off the blues even with help from my family or friends (rate 0 to 3 points)	
2. I felt depressed (rate 0 to 3 points)	
3. I felt fearful (rate 0 to 3 points, using the earlier rating scale)	
4. My sleep was restless (rate 0 to 3 points)	
5. I felt hopeful about the future. (Reverse scoring)	
Rating for #5 only	**Score**
Most of the time	0
Moderately or much of the time	1
Some of the time	2
Rarely	3

When the patient does not know one of the answers, you may score that answer as the average of all other scores. If the patient cannot answer more than one question, the validity of the test is compromised.

A score of 4 or more is a positive screen (Y) for depression. Proceed to a more thorough assessment of depression.

*These screeners are part of the VHA Clinical Guideline for Major Depressive Disorder (MDD), MDD with PTSD, MDD with Substance Abuse and may be referred to for additional information.

Rating for questions 1, 2, 3, and 4 only Score
Rating for #5 only Score

Domain: Cognitive Function

	Suggested Questions	*Comments*
Mental Status	Spell your whole name.	
	What is your address including the zip code?	
	What is your date of birth?	
	How old are you?	
	What is today's date?	
Memory Test	You name three unrelated objects, clearly and slowly, allowing about one second for each.	
	After you have said all three words, ask the patient to repeat them.	

Possible Problem Labels	*Identified Problems*
Impaired mental abilities.	
Inability to understand.	
Inability to follow instructions.	
Memory loss.	
Inability to communicate.	

Domain: Functional Status

	Suggested Questions	*Comments*
Activities of Daily Living	Are you able to take care of all your personal needs by yourself?	
	Do you need help with (Who helps with?):	
	preparing your meals?	
	eating?	
	taking a bath	
	getting dressed?	
	getting to the toilet?	
	taking medications?	
	housekeeping chores?	
	shopping and errands?	
	transportation?	

	Possible Problem Labels	*Identified Problems*
	ADL deficit.	
	Inability to maintain personal hygiene.	
	Inadequate support system.	
	Other problems:	
Instrumental Activities of Daily Living	Are you able to clean your own home?	
	Dust? Vacuum? Clean floors?	
	Do you need help (Who helps?) with:	
	shopping for food?	
	meal preparation?	
	writing checks?	
	using the telephone?	

Domain: Functional Status

	Possible Problem Labels	*Identified Problems*
	IADL deficit.	
	Reduced independence.	
	Inadequate support system.	
	Inability to maintain environment.	
	Other problems:	
Vision/Hearing Abilities	Do you have problems seeing? (If yes, is it making it hard to follow your doctor's instructions?)	
	Do you have hearing problems? (If yes, is it making it hard to follow your doctor's instructions?)	
	Possible Problem Labels	
	Visually impaired.	
	Hearing impaired.	
Mobility/Falls	How many falls have you had in the past year?	
	Have you had any falls while walking or getting in or out of bed?	
	How did the fall happen?	
	Have you had a serious injury from a fall?	
	Are you able to move about your home without help? (Do you use a cane or walker?)	
	Do you need help with:	
	Walking outside?	
	Getting to the doctor's office?	
	Climbing stairs/steps?	
	Bending, kneeling, or stooping?	

Domain: Functional Status

Possible Problem Labels	*Identified Problems*
Mobility problems.	
Home not safe.	
Lack of proper lighting.	
Not using non-slip mats in areas that get wet.	
Using scatter rugs.	
Home is cluttered.	
No handrails on the stairways.	
Floors highly polished.	
Other problems:	

Domain: Home Environment

	Suggested Questions	*Comments*
Type of Residence	Do you live in your own house? Apartment?	
	Condominium or mobile home?	
	Do you live in an assisted-living apartment, board and care home or nursing home?	
	Do you live with someone? Whom?	
Dwelling Description		
Home	One floor? Two floors?	
	Where is the bathroom located?	
	Do you use any devices such as grab bars, etc. in your bathroom to help you?	
	Would it help to have any assisted devices?	
	What kind of coverings are on the floor?	
	Wall to wall carpets? Rugs?	
	Where do you do your laundry?	
Stairs	Can you get into and out of your home safely?	
	Are there stairs at the entrance?	
	Can you negotiate the stairs safely inside your home?	
	Outside your home?	
Telephone	Do you have a phone?	
	If not, how do people reach you?	
	How do you get in touch with others?	
	Do you have any trouble seeing the dial or hearing the phone when it rings?	
	Do people say they have called you and you didn't hear the telephone ring even though you were home?	

Domain: Home Environment

Utilities

What kind of heating do you have? _____

Do you feel cold during the winter? _____

Do you have air conditioning? _____

Do you have a smoke detector near your bedroom? _____

In your kitchen? _____

Sanitation

Are running water, toilets available? _____

Are rodents or roaches a problem? _____

Possible Problem Labels	***Identified Problems***
Lives alone.	_____
Unable to do routine chores.	_____
Physically unsafe at home.	_____
Can't exit home easily in emergency.	_____
Doesn't have phone access.	_____
Inadequate water/sewage system.	_____
Inadequate pest control.	_____

Domain: Patient Support System

Suggested Questions ***Comments***

Is there someone that helps you at home, i.e. _____

Caregiver (CG)? _____

If yes: _____

Name: _____

Relationship: _____

Phone #: _____

About how often does this person come to help you out? _____

What formal services are you receiving in the home? _____

Service	Agency	Frequency	Payment Source

Do you have a backup plan if your caregiver is unable to assist you? _____

Do you go to an adult day care center? How often? _____

Possible Problem Labels ***Identified Problems***

Inadequate support. _____

Unreliable caregiver. _____

Limited caregiver ability. _____

Domain: Caregiver Support System

Ask the following questions of the appropriate caregiver, i.e., family, friends, and/or neighbors:

a. At what point would you feel unable to continue your caregiving?

b. Does your health or other event in your life impact your caregiving abilities?

c. Do you have emergency plans?

Family:
a. _____
b. _____
c. _____

Friends:
a. _____
b. _____
c. _____

Neighbors:
a. _____
b. _____
c. _____

Assess the need for spiritual support. _____

Assess the need for referral to appropriate support groups. _____

Name a:

Backup caregiver: _____

Backup plan: _____

Comments: _____

Possible Problem Labels:	***Identified Problems***
Limited ability of caregiver.	_____
Caregiver overwhelmed.	_____
Lacks backup plan.	_____

Domain: Spiritual Assessment

	Suggested Questions	*Comments*
Belief System	What is your formal religious affiliation?	
	Do you practice your religion?	
	What do you accept and not accept in your religion?	
	What is the importance of spirituality/ religion in your daily life?	
	Do you rely on prayer to effect change?	
	Possible Problem Labels	***Identified Problems***
	Inadequate religious support for ethical dilemmas.	
	Other problems:	
Rituals/ Practices/ Restrictions	Are there specific practices that you carry out as part of your religion or spirituality.	
	Possible Problem Labels	***Identified Problems***
	Conflicting spiritual beliefs and recommended medical regimen.	
	Other problems:	
Implications for Medical Care	What aspects of your religion/spirituality would you like me to keep in mind as I care for you?	
	Are there any specific cultural healing practices that are important to you for your care?	
	What knowledge or understanding would strengthen our relationship as care provider and patient?	
	Possible Problem Labels	***Identified Problems***
	Spiritual beliefs have implications for medical care	
	Other problems:	

Domain: Spiritual Assessment

End of Life Planning

As we plan for your care near the end of life, how does your faith impact on your decisions? _____

Have you recently completed advanced directives including a living will and durable power of attorney? _____

Have you completed an advanced directive? _____

Are there particular aspects of care that you wish to forgo or have withheld because of your faith? _____

Possible Problem Labels	***Identified Problems***
Inadequate knowledge about advanced directives.	_____
Other problems:	_____

Domain: Financial Status

	Suggested Questions	*Comments*
Work	Do you work 40 hours a week or are you retired?	
	Do you contribute to a pension plan?	
	What is your monthly income?	
	What percentage of your salary do you save?	
	Do you contribute to Social Security?	
	Do you receive Social Security payments monthly?	

	Possible Problem Labels	*Identified Problems*
	No stream of income for support.	
	Fails to contribute to pension plan.	
	No plan for retirement.	
	Other problems:	

Health Insurance	Do you have health insurance?	
	Do you have an insurance card?	
	Medicare? Parts A and B?	
	Are you eligible for Medicaid?	
	Do you have a supplemental policy?	

	Possible Problem Labels	*Identified Problems*
	Inadequate health insurance coverage.	
	Doesn't understand difference between Medicare/Medicaid.	

Domain: Financial Status

Budgeting

Who pays the bills in your household and keeps track of expenditures? _____

Do you have any assets? _____

Do you own your own home? _____

Are you in debt? _____

Can you meet basic financial obligations-rent, food, utilities? _____

Do you rely on someone else for money to support basic necessities? _____

Can you pay for necessary medical supplies, medications and miscellaneous? _____

Possible Problem Labels	***Identified Problems***
Inadequate ability to budget or handle money.	_____
Dependent on someone else for support.	_____
Inadequate resources to support basic needs.	_____
Inadequate resources to purchase medical supplies.	_____

Care Management Needs Planning

Patient PCP SSN

Problem	Plan/Intervention	Goal/Expected Outcome	Date Achieved

Care Manager Date of Assessment

Improving Interviewing Skills

In order to gather the necessary information about a patient and to ensure that the assessment experience is positive for both the patient and the interviewer, it is important that care managers develop and/or enhance their interviewing skills.

The five guidelines suggested by King* that can help set the stage for a successful interview include:

Ask the questions on the assessment tool. It is important not to skip areas defined on the assessment tool because the care manager thinks she/he knows the answer. Getting correct and reliable information is important for the development of the treatment plan. As previously indicated, the questions can be changed or amplified for particular patients. Before the assessment begins, the care manager should know:

- what each question means and how to reword a question to adapt to unusual or difficult situations.
- the boundaries of each question
- how to answer questions to reassure the patient of the value of the assessment.

Spend time to develop rapport with the patient. It is more likely that the patient will be open and that the interview will proceed effectively when the care manager takes the time and effort to develop a good rapport with the patient. King suggests that rapport can be developed by:

- speaking in a conversational tone
- engaging in small talk with the patient
- reassuring the patient that the assessment is important and a valuable aspect of his care
- answering questions directly
- listening to the patient and making a mental note of the patient's style of communicating (e.g. talkative or quiet?)
- letting the patient know talking with them is enjoyable
- observing the patient's behavior in the presence of others
- spending some time discussing the assessment before beginning
- always being professional but not being afraid to enjoy the process

Avoid bias or leading the patient. Bias can easily change an answer or an opinion offered by the patient. Bias can be minimized by:

- not expressing opinion or how you think the patient should respond
- not suggesting answers
- not using leading probes
- not rushing the patient to answer the question

Probe appropriately. Probes can ensure that information gathered about the patient is correct , clear and complete.A good probe encourages further conversation without biasing the response.

Do not avoid difficult situations. When a patient is experiencing strong feelings of anger, grief, anxiety, etc., a care manager can handle the situation by

- being polite, direct and sensitive and not ignoring the patient
- not pitying the patient
- continuing on with the assessment, if possible

King suggests that these guidelines form the foundation to help improve assessment interviewing skills. Interview training can be developed around these guidelines as well as role-playing and brainstorming about questions that patients might have.

*King C. **Guidelines for improving assessment skills.** Generations 1997;21:73-75

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Health Status of Veterans: Physical and Mental Component Summary Scores (SF-36V)

1996 National Survey of Ambulatory Care Patients Executive Report

OVERVIEW OF REPORT

What is the overall purpose of measuring the health status of veterans in the VHA?

For an aging VA population with a predominance of chronic diseases, the goals of patient care within VGA are no longer focused solely on survival or curing the disease, but on optimizing patient's functional health and well-being through ambulatory care and other extended care programs. This shift in the objectives of VHA patient care indicate that there is a need to define the health status, e.g., their physical, psychological, social, and role functioning abilities in managing daily living. These functional health assessments, derived directly from the patients by structured questionnaire, are important indicators of the disease burden of the patients (Kazis et al. 1997)[1]. Functional measures are summarized into reliable and valid quantitative assessments.

Functional measures are a function of the patient's comorbidities. They are a proxy for the patient's case-mix at a particular point in time or cross-sectionally. They provide an important baseline assessment that explain a substantial part of the mix of the patient's morbidities or presence of diseases. As indicators of case-mix, these measures contribute to a uniform approach for gauging the health status of patients who are involved in the care process. Measures of functional status when reported for groups of patients give a relative indication of their disease burden at that level of aggregation. Higher levels of aggregations of these measures are applied for comparisons across hospital sites and VISNs. Differences observed by hospital sites and VISN may have important implications for the 'patient needs' or 'level of disease burden' of a hospital or VISN with important implications for resource requirements for the patients actively served by the health care system.

This report presents baseline scores for each of the VISNs and hospitals which will be used in developing VISN Performance Measures based on functional status for the year 2000. In this context, these measures will be used to evaluate the health benefits of outcomes of medical care. As such, they are valuable tools for monitoring demands for health care services as well as it's efficiency and effectiveness, particularly as the goals of health care broaden and focus on optimizing patient functional health and well-being.

1. Kazis LE. Miller DR. Clark J. Skinner K, Lee A. Rogers W. Spiro III A. Payne S. Fincke G. Selim A. Linzer M. Health related quality of life in VA patients results from the Veterans Health Study. (submitted for publications).

SUMMARY OF RESULTS

Rapid Collection and processing of health status measures is feasible.

The overall response rate was 76.6% (32.631/42.595). Brief measures of health are clinically valid and reliable.

Most VISNs in the Northeast, Midwest, and West have higher PCS scores and MCS scores. Most VISNs in the southern regions have lower PCS and MCS scores, respectively, indicating greater disease burden and case mix.

Differences in PCS and MCS scores across VISNs are due in part to differences in the populations served. Selection factors that include income and service connected disability status account for a good deal of the differences (see appendix for details).

There are substantial case mix differences across VISns. Veterans sampled have substantially greater disease burden than those ambulatory patients in the civilian sector.

Differences in physical (PCS) and mental (MCS) component summary scores varied by more than 60% of a standard deviation across the 22 VISNs (lower scores mean worse health): from 27.9 to 34.5 for PCS and from 37.6 to 44.2 for MCS. Scores are also substantially lower than the general U.S. population with a mean of 50. Other comparisons with results from the Medical Outcomes Study (MOS)—civilian ambulatory patient populations from Boston, Chicago, and Los Angeles—indicate differences that are at least 50% of a standard deviation worse for the veteran users than MOS patients.

There are substantial case mix differences by hospital within VISNs.

In some cases, differences by hospital within VISNs differed by more than 100% of a standard deviation. These differences contribute to an understanding of the patient populations served by a VAMC. They may also contribute to understanding the different resource requirements of the populations using particular facilities because of their differing case mix.

These differences in physical and mental component scores have specific interpretations.

- **Clinical Impacts**
  Having Scores that are at least 10 points lower on PCS or MCS is equivalent to having approximately two additional chronic conditions on average. For example, having diabetes is equivalent to a score that is 3 points lower on PCS while having depression is equivalent to a score that is 8 points lower on MCS.
- **Utilization of Services and Costs**
  After enrolling for age, a veteran who is 10 points lower on PCS will have a cost that is $2,183 greater per year than the Capitation Advisory Panel and $2,081 greater than the CAP model for MCS.
- **Survival**
  A veteran population with PCS scores 10 points lower has about a 74% greater chance of dying, whereas those with 10 points lower for MCS have a 28% greater chance of dying over a period of two years.

Interpretive guidelines are given in the appendix.

OVERVIEW OF REPORT

How do we measure the health status of patients in this report?

The SF-36V (Short Form 36 Item Health Survey for Veterans), adapted from the (Medical Outcomes Study) MOS SF-36, is a patient-based questionnaire designed specifically for use among veterans who are in ambulatory care (Kazis et al, 1997)[2]. The SF-36V is a reliable and valid measure of health status that has been widely used, disseminated and documented in the VHA. The SF-36V measures eight concepts of health: physical functioning, role limitations due to physical problems, bodily pain, general health, energy/vitality, social functioning, role limitations due to emotional problems, and mental health (See Table 1, p.87).These eight concepts have been summarized into two summary scores, a physical component summary (PCS) and a mental component summary (MCS). The two summary component scales PCS and MCS were each scored using weight derived from a national and norm-based so that scores have a direct interpretation in relation to the distribution of scores in the U.S. population with a mean of 50. Higher scores mean better health. All SF-36V results in this report have been rescored so that they are comparable to the original version of the MOS SF-36 for comparisons with established norms outside VHA.

What are the methods for measuring health status in this report?

This report uses a survey methodology with active users of the VA ambulatory care system to determine the case mix or variation in illness burden of patients n a uniform fashion across the VHA system. This may have important implications for the burden of case required and future utilization services.

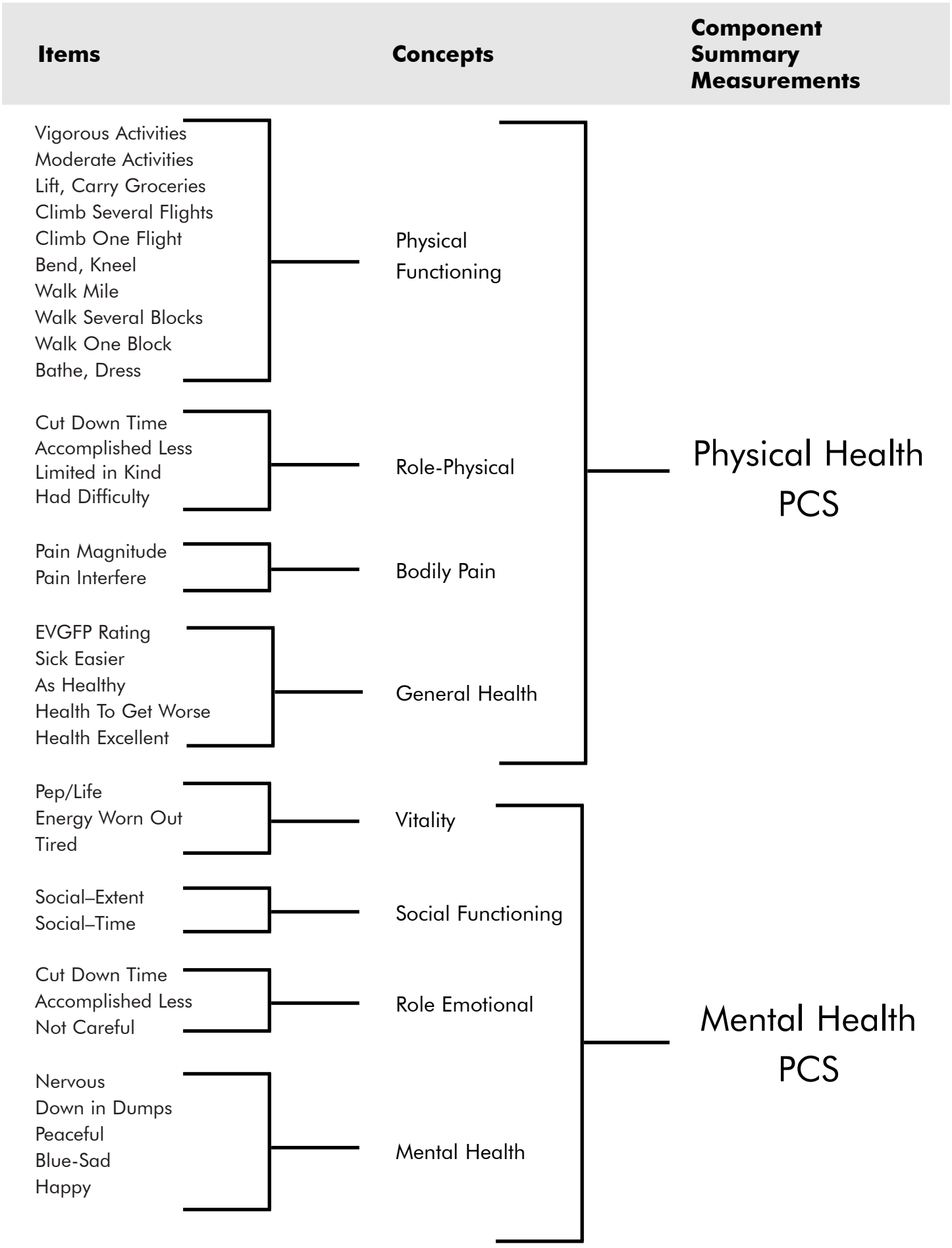
What is the sampling strategy for this report?

The SF-35V was included along with the Customer Satisfaction Survey (CSS) by the National Customer Feedback Center (NCFC) administered between September and October 1996 at 156 VAMCs. All patients in the sample were active patient users of VHA ambulatory care, with at least one primary care visit and one specialty care visit in the past six months. All VHA hospitals were represented in the sample with an average of at least 114 completed surveys per facility. A modified Total Design Methodology approach developed by Dillman (1978)[3] was used to maximize response rates (details of this methodology are included in the appendix).

2. Kazis LE. Miller DR. Clark J. Skinner K. Lee A. Ren XS. Spiro ILL A. Rogers W. Ware J. Improving the response choices on the SF-36 role functioning scales: Results from the Veterans Health Study (SF-36V). (submitted to publication).

3. Dillman DA. Mail and Telephone Survey: The Total Design Method New York: John Wiley and Sons (1978)

SF-36V Measurement Model*(Table 1)



Health Assessment

Health Assessment Project
VA Clinic Update SF-36V

(The following document has been reformatted for the purposes of this booklet.)

Instructions: This survey asks for your views about your health. This information will help keep track of hw you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: *(Fill in one circle on each line.)*

❍	❍	❍	❍	❍
1	2	3	4	5
EXCELLENT	VERY GOOD	GOOD	FAIR	POOR

2. **The following questions are about activities you might do during a typical day. Does *your health now limit you* in these activities? If so how much?**

	YES, LIMITED A LOT	**YES, LIMITED A LITTLE**	**NO, NOT LIMITED AT ALL**
a. **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports?	1 ❍	2 ❍	3 ❍
b. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	1 ❍	2 ❍	3 ❍
c. **Lifting,** or carrying groceries?	1 ❍	2 ❍	3 ❍
d. Climbing **several** flights of stairs?	1 ❍	2 ❍	3 ❍
e. Climbing **one** flight of stairs?	1 ❍	2 ❍	3 ❍
f. Bending, kneeling, or stooping?	1 ❍	2 ❍	3 ❍
g. Walking more than a **mile?**	1 ❍	2 ❍	3 ❍
h. Walking **several** blocks?	1 ❍	2 ❍	3 ❍
i. Walking **one** block?	1 ❍	2 ❍	3 ❍
j. Bathing or dressing yourself?	1 ❍	2 ❍	3 ❍

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?*

	NO NONE OF THE TIME	YES, A LITTLE OF THE TIME	YES, SOME OF THE TIME	YES, MOST OF THE TIME	YES, ALL OF THE TIME
a. Cut down the amount of time you spend on work or other activities.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
b. **Accomplished less** than you would like.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
c. Were you limited in the **kind** of work or other activities.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
d. Had difficulty performing the work or other activities (for example, it took extra effort).	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

	NO NONE OF THE TIME	YES, A LITTLE OF THE TIME	YES, SOME OF THE TIME	YES, MOST OF THE TIME	YES, ALL OF THE TIME
a. Cut down the **amount of time** you spent on work or other activities?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
b. **Accomplished less** than you would like.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
c. Didn't do work or other activities as c**arefully** as usual.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍

5. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

❍	❍	❍	❍	❍
1	2	3	4	5
NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY

6. How much bodily pain have you had during the past 4 weeks?

❍	❍	❍	❍	❍	❍
1	2	3	4	5	6
NONE	VERY MILD	MILD	MODERATE	SEVERE	VERY SEVERE

7. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and house work)?

❍	❍	❍	❍	❍
1	2	3	4	5
NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY

8. These questions are about how you feel and how things have been during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling. How much time during the past 4 weeks:

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Did you feel f**ull of pep**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
b. Have you been a very **nervous person**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
c. Have you felt so down in the dumps that **nothing could cheer you up**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
d. Have you felt **calm and peaceful**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
e. Did you have a **lot of energy**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
f. Have you felt **downhearted and blue**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
g. Did you feel **worn out**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
h. Have you been a **happy person**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍
i. Did you feel **tired**?	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍

9. During the past 4 weeks, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

❍	❍	❍	❍	❍
1	**2**	**3**	**4**	**5**
ALL OF THE TIME	**MOST OF THE TIME**	**SOME OF THE TIME**	**A LITTLE OF THE TIME**	**NONE OF THE TIME**

10. Please choose the answer that best describes *how true or false* each of the following statements is for you.

	DEFINITELY TRUE	MOSTLY TRUE	NOT SURE	MOSTLY FALSE	DEFINITELY FALSE
a. I seem to get sick a little easier than other people.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
b. I am as healthy as anybody I know.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
c. I expect my health to get worse.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍
d. My health is excellent.	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍

Now, we'd like to ask you some questions about how your health may have changed.

11. Compared to one year ago, how would you rate your *physical health* in general now?

❍	❍	❍	❍	❍
1	2	3	4	5
MUCH BETTER	SOMEWHAT BETTER	ABOUT THE SAME	SOMEWHAT WORSE	MUCH WORSE

12. Compared to one year ago, how would you rate your *emotional problems* (such as feeling anxious, depressed or irritable) *now*?

❍	❍	❍	❍	❍
1	2	3	4	5
MUCH BETTER	SOMEWHAT BETTER	ABOUT THE SAME	SOMEWHAT WORSE	MUCH WORSE

13. What is your gender/sex? ❍ 1 male ❍ 2 female

14. What is the highest grade in school you have completed?

								HIGH SCHOOL --------				COLLEGE ----------				GRAD-
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

15. What is your race? *(Fill in one circle)*

❍ Aleutian, Eskimo or American Indian
❍ Asian or Pacific Islander
❍ Black
❍ Hispanic Black
❍ Hispanic White
❍ White

16. Has your doctor ever told you that you have any of the following?

	YES	**NO**
a. Asthma, emphysema or chronic bronchitis (or chronic obstructive pulmonary disease)	1 ❍	2 ❍
b. Hypertension	1 ❍	2 ❍
c. Diabetes	1 ❍	2 ❍
d. Arthritis (including rheumatoid or osteoarthritis)	1 ❍	2 ❍
e. Depression	1 ❍	2 ❍
f. Myocardial infarction, heart attack or heart problems including angina	1 ❍	2 ❍

EDUCATION

THE CASE STUDIES

1. Mr. Brown
A 75-year old male, divorced, with metastatic adenocarcinoma of prostate post lumbar radiation. History of multiple bilateral pulmonary lesions. History of Barrett's esophagus. Demonstrates poor compliance with meds and appointments. Lives alone with no social support system since no contact with two sons. Having difficulty managing in current housing -- problem with roaches and unsafe area. Non service connected with limited income. Does not like senior centers or groups but is also lonely and isolated. Living situation is not adequate. Unable to prepare meals, weight loss due to poor appetite and alcohol use. Followed in Hemoc/Oncology and Primary Care Red Team. Impaired vision and hearing (no hearing aid). Not taking meds (Ticlid, Isosorbide, Omerprazole) regularly, some chest pain which is controlled with nitroglycerine. Has no Durable Power of Attorney for Health Care.

Discuss considerations.
List 8 to10 treatment goals.

2. Mr. Smith
A 77-year old non-service connected, never married male. Not showing up for regular appointments in Blue team. When he comes he is anxious, paranoid, unkempt. Recently seen for emergency care at private hospital for shortness of breath. Not following through with arranging prescription refills. Is virtually deaf and all communication has to be written. Activities of daily living independent except unable to manage public transportation. Cannot afford taxi service so does not always make appointments. Sister with whom he lived for many years recently died. He does not know how to manage health care needs, medications and personal matters and is months behind on paying bills. Heat has been turned off in apartment. Is paranoid and convinced that the government is trying to kill all old people in order to eliminate the national debt. Refuses referral to mental health. Overweight by 25 pounds. Dental problems, not eligible for VA dental care.

Discuss considerations.
List 8 to 10 treatment goals.

3. Mr. Doe
A 75-year old veteran with prostate cancer. He is status post transurethral prostatectomy 5 years ago and had hormone therapy. He has been told he now has metastasis to the bone. The patient's urologist is referring him to a radiation oncologist for radiation treatment of the prostate. Mr. Doe wants no further treatment.

How would you intervene in this situation?
As the Care Manager, how would you abide by the patient's wishes and act as his advocate?
Discuss considerations.
List 8 to 10 goals.

4. Ms. Doe
A 75-year old female veteran. She suffers from chronic schizophrenia, she is also a diabetic, and she weighs 280 pounds. She is a borderline hypertensive patient. She is almost edentulous with only a few remaining teeth which makes healthy eating difficult for her. She is on insulin, but does not take it on a regular basis because she does not like to give herself injections. Her primary care provider is reluctant to start her on Rezulin due to her many no-shows and the fear she might not adhere to lab tests for liver function studies.

(She has left the clinic before without going to the lab as requested.)
How would you, as her Care Manager, involve her in her care and seek patient engagement in the treatment process?
Discuss considerations.
List 8 to 10 goals.

5. Mr. Johnson

A 56-year old white male with end stage congestive heart failure and chronic obstructive pulmonary disease. He also has significant coronary artery disease. He receives primary care (PC) follow up through a Home Based PC program. He lives with his supportive wife Ann and their 4 adult children from previous marriages. Mr. Johnson is maintained on continuous oxygen via nasal cannula and experiences dyspnea with mild exertion. He also experiences significant anxiety with the slightest change in status. Baseline vital signs are BP 85-95/50-60, P 50-70, atrial fibrillation. Mr. Johnson has had acute care hospital admissions every month for the last 8 months. Admission diagnoses: rule out myocardial infarction, hypotension, chronic obstructive pulmonary disease exacerbation and rule out syncope.

Please identify and prioritize Mr. Johnson's problems.
Identify resources needed to address the problems.
Discuss considerations.
List 8 to 10 goals.

6. Mrs. Brownell*

Age 77 and widowed, lives in a supervisory care setting where she has her own room and bathroom. The minimum requirement for living in this setting is the ability to get to and from the bathroom and dining room independently. Prior to this admission, Mrs. Brownell was alert and oriented and able to ambulate independently with a walker.

Mrs. Brownell's past history includes gastrointestinal bleeding from ulcers, non-insulin-dependent diabetes mellitus, hypertension, breast cancer with bilateral mastectomies 12 years earlier, atrial fibrillation, a cerebral vascular accident 5 years earlier, and alcohol abuse with hepatic cirrhosis and hepatic encephalopathy. She now presents to the hospital with a cough with brown sputum, diarrhea, mental status changes, and a decreased ability to ambulate because of weakness, falling at home, and anorexia. A left facial drop and right-sided weakness are also noted.

Mrs. Brownell was admitted with bilateral pleural effusions noted on chest x-ray, specifically Klebstella pneumonia found by sputum culture. Her blood area nitrogen (BUN) was 50 and her white blood cell count was 19.5 TH/UL. She was immediately hydrated and placed on IV antibiotics. A computed tomography (CT) scan of the head revealed nothing except for some ischemic small vessel disease. X-rays revealed the possibility of metastases; therefore, a bone scan was ordered. Uptake was noted in the thoracic and lumbar areas, but these findings were more consistent with degenerative or osteoarthritic changes.

During the course of hospitalization, Mrs. Brownell's mental state and weakness improved. Physical therapy was instituted.

It is the anticipated day of discharge, since all antibiotics are oral and Mrs. Brownell's temperature has remained normal for 24 hours. She is eating 100% of her diet, and her lab values are within normal limits. She can walk 20 to 40 feet with a minimum of assistance but cannot get up and out of bed independently, secondary to severe back pain.

As her Care Manager, what are your goals and considerations?

*Taken/adapted from Powell SK. *Nursing case management: A practical guide to success in managed care.* Philadelphia (PA): Lippincott-Raven; 1996. 392p.

A GUIDE FOR THE REVIEW OF THE CARE MANAGEMENT CASE STUDIES

I. Look at Role Definitions

1. What might the Care Manager do in this situation?

II. Assess Strengths in Each Case Study

1. Is there a strong support system? This may include family, significant others, friends, neighbors, and any informal support that can be tapped.
2. Does the patient or family have the financial ability to provide the patient with the best possible living situation and health care?
3. Does the patient have entitlement for VA benefits?
4. Is there a private insurance policy that would help supplement their VA care?
5. Does the patient have positive emotional, mental, and spiritual resources?
6. Are there cultural and religious factors that may impact response to health care?

III. Consider Limitations in Each Case

1. Assess knowledge deficits, both in the patient and in any caregivers.
2. Assess insurance coverage.
3. Assess social support.
4. Assess housing situation.
5. Assess limitations due to poor medical status that cannot be changed or improved.
6. Consider the limitations resulting from noncompliance.
7. Assess financial status.
8. Assess which limitations might be improved and plan strategy.
9. Assess developmental stage as a factor that may impact health care.

IV. Implement and Coordinate Care

1. Develop and follow a plan of care.
2. Determine appropriate utilization of resources.
3. Assess for quality of care and use of standardized medical guidelines.
4. Assess the status of advanced medical directives and need for end of life planning.
5. Communicate and collaborate a care plan with the team for post-hospital or continuing care.
6. Assess availability of public community resources.
7. Determine level of rehabilitation needed. This may range in scope from in-home to institutional rehabilitation.

8. Assess the home environment for safety.
9. Contact veteran's groups/organizations as appropriate.

V. Address

1. Are there any psychological issues such as competency, severe disability, danger to self, and danger to others?
2. Are there any substance abuse issues?
3. Are there any adult or child abuse issues?
4. Assess the need for ethics committee involvement.
5. Determine any legal issues that need attention.
6. Assess functional impairments.

Finally, after you do everything you can, the veteran may still experience a negative outcome. Keep this in mind and don't get discouraged.

*Taken/adapted from Powell SK. *Nursing case management: A practical guide to success in managed care.* Philadelphia (PA): Lippincott-Raven; 1996. 392p.

CERTIFICATION AND EDUCATION RESOURCES

The information about certification and programs to prepare for certification are provided as resources. You will need to investigate the certification and preparatory program to determine if they will meet your needs as a Care Manager in VA. Nurses may want to check with the Office of the Nursing Strategic Health Group in Headquarters to find out the specific certifications that are recognized by VHA. The phone number is (202) 273-8421. The two case management certifications recognized by VHA are the American Nurses Credentialing Center and the Center for Case Management.
Note: Cost figures cited may have changed.

PREPARATORY COURSES/STUDY GUIDES FOR CCM CERTIFICATION

Case Management 2000
P.O. Box 3383
Allentown, PA 18106-0383
(800) 226-4266, (610) 838-2608
Fax: (610) 967-3503

This course is designed as a comprehensive and logical approach to the study of the five core content areas of the Case Management Certification exam, as outlined by the Commission. The approximate cost of this one day seminar is $165.00. Course audio tapes are available at a cost of $165.00. A practice exam including results with outline of strong and weak areas is also available at a cost of $99.00.

Datachem Software, Inc.
222 Turnpike Road
Westboro, MA 01581
(800) 377-9717
Fax: (508) 366-5278
www.datachemsoftware.com

Datachem offers a software program which covers all aspects of the CCM examination. This program simulates the examination and provides complete explanations for each question. The questions, answers and explanations may be printed out to strengthen your understanding. This company guarantees that you will pass the exam or your money will be refunded. The single user cost of this program is $299.95.

Elliott & Fitzpatrick, Inc.
P.O. Box 1945
Athens, GA 30603
(800) 843-4977, (706) 548-8161
Fax: (706) 546-8417

The Study Guide for the Certified Case Managers Exam is available from Elliott & Fitzgerald at a cost of $24.95. This publisher also offers a variety of rehabilitation, life care planning and vocational resources. Study guides for the CDMS and CRC exams are also available.

Medical Management Development Associates, Inc. (MMDA)
10949 Technology Place
San Diego, CA 92127
(800) 255-3276
Fax: (619) 674-1458
www.mmdainc.com

Medical Management Development Associates, Inc. provides educational seminars for healthcare professionals across the country. The Certification Preparation Course for Case Managers is a one day course that assists in evaluating career goals, preparing for the CCM exam and highlighting the core competency areas needed for successful completion in becoming a Certified Case Manager. The cost of the seminar ranges from $215.00 to $295.00.

University of Florida/Intelicus – Life Care Planning Certificate Program
Intelicus (formerly Rehabilitation Training Institute)
2710 Rew Circle
Ocoee, FL 34761
(800) 431-6687
Fax: (407) 656-7585
http://www.intelicus.com

This program is composed of six training sessions and two distance learning modules offering up to 120 post-graduate hours in professional training focused on Life Care Planning for Catastrophic Case Management including Vocational Issues that are vital in Life Care Planning. Approximate cost of each module is $445.00. At the completion of the program, Intelicus will forward the graduate's name and address to CDED. CDED will then send an examination application and information about the certification to the graduate. Certification is independent of University of Florida/Intelicus.

HOME STUDY COURSES

American Schools Association
P.O. Box 550
Norcross, GA 30091-0550
(800) 230-2263

Home study courses are a way to earn Continuing Education for Certification Maintenance. A variety of courses are available at a cost that ranges from approximately $60.00 to $175.00.

CMR Home Study
2899 Agoura Road, Suite 160
Westlake Village, CA 91361-3200
(818) 706-1671
Fax: (818) 879-8379

Home study courses are available for Certification Maintenance (CRC, CDMS, CCM, RN, CVE/CWA, NCC, LPC). A variety of courses are available at a cost that ranges from approximately $65.00 to $135.00.

The Foundation for Rehabilitation Education and Research
1835 Rohlwing Road, Suite E
Rolling Meadows, IL 60008
(847) 818-1967
Fax: (847) 394-2172
A home study course entitled, Professional Ethics in the Rehabilitation Field, is available from the Foundation. This manual includes five modules covering the following content: Introduction to Ethical Principles; Recognizing Ethical Dilemmas; Ethical Decision-Making; Confidentiality; and Case Studies in Ethics. The course is approved for 10 clock hours of CE credit for CRC, CDMS and CCM certifications. The cost of this manual is $140.00.

The Hatherleigh Company
1114 First Avenue
Suite 500
New York, NY 10021
(800) 367-2550
Fax: (212) 832-1502
www.hatherleigh.com

Home study courses are available for Certification Maintenance (CRC, CDMS, CCM, NBCC, NAADAC, CCWAVES, APA). Offerings include Directions in Psychiatric Nursing; Directions in Rehabilitation Counseling and The Second Decade of AIDS: Mental Health Practice Handbook. The cost of programs ranges from approximately $25.00 to $267.00.

CASE MANAGEMENT EDUCATION AND CONFERENCES

Case Management Institute of Connecticut Community Care
43 Enterprise Drive
Bristol, CT 06010-7472
(800) 972-3851 Ask for Cheryl Whitman or Helen Notarangelo.

Full and half-day seminars on care and case management. Offerings include physical aspects of aging, humor in care management, super caregiver syndrome, and comprehensive assessment. Call toll-free number above for free catalog of seminars.

Case Management Society of America
8201 Cantrell Road, Suite 230
Little Rock, AR 72227
(501) 225-2229
Fax: (501) 221-9068
www.cmsa.org

CMSA offers an annual conference for case managers which allows the attendee to learn from a diverse group of speakers and network with their peers and the visionary leaders of the case management industry. The cost ranges from $425.00 to $615.00. For further information or a conference brochure, call CMSA at (501) 225-2229.

Contemporary Forums
11900 Silvergate Drive
Dublin, CA 94568-2219
(510) 828-7100
Fax: (510) 828-2121
www.cforums.com

Contemporary Forums offers programs which meet the continuing education needs of physicians, nurses and other health professionals. These programs are fully accredited by ACCME and ANCC. Seminars are offered at various geographic locations throughout the United States and include any topics that are of interest to the case manager. A national conference entitled Case Management Along the Continuum, is of particular interest to the case manager who functions in the hospital, community or long term care setting.

Creative Healthcare Management
Minneapolis, MN
(800) 728-7766

This group offers a Competencies for Case Management Seminar which can be provided for companies, large groups and/or within facility based case management programs.

H & L Case Management 2000
P.O. Box 3383
Allentown, PA 18106-0383
(800) 226-4266, (610) 838-2608
Fax: (610) 967-3503
www.cm2000.com

Case Management 2000 offers a basic case management practice training program. This two-day course encompasses a comprehensive approach to the case management process. Seminars are offered at various geographic sites throughout the United States. The approximate cost is $320.00. Course audio tapes are available at a cost of $295.00.

Intelicus
2710 Rew Circle
Suite 100
Ocoee, FL 34761
(407) 656-3906
Fax: (407) 656-7585

Intelicus is a partnership owned jointly by the University of Florida and TKG (The Kirven Group). Offers a certificate program in life care planning. Applicants must have a bachelor's in an appropriate field, preferably rehabilitation. Must complete 120 hours for the certificate program. Program recognized as provider of continuing education hours for several national accrediting and licensing boards. Courses divided into eight modules. Modules one through six are two-day sessions. Cost: $445.00. Module seven is self-study. Cost: $225.00. Module eight requires applicants to complete life care plan in six weeks. Plan reviewed with detailed critique. Cost: $445.00 Cost per modules: $495.00 for late registration. Courses offered in several locations nationwide.

Medical Management Development Associates, Inc. (MMDA)
10949 Technology Place
San Diego, CA 92127
(800) 255-3276
Fax: (619) 674-1458
www.mmdainc.com

Medical Management Development Associates, Inc. provides educational seminars for healthcare professionals across the country. Several courses applicable to case management are available including The Effective Case Manager and Advanced Utilization Management Strategies. Costs range from $215.00 to $295.00.

Mosby-Year Book, Inc.
11830 Westline Industrial Drive
St. Louis, MO 63146
(313) 579-2867
(800) 325-4177
www.mosby.com
Mosby offers an annual conference which is designed to meet the continuing education needs of the case manager.

Professional Resources in Management Education (PRIME)
1820 S.W. 100 Avenue
Miramar, FL 33025
(954) 436-6300
Fax: (954) 432-5858
www.accesrehab.com

Presents full-day course called "The Process of Case Management: Basic to Advanced." Offers certificate of completion and eight hours of continuing education for nurses. Attendees receive 200-page workbook. Cost: $175.00. Other programs available including in-house training programs.

Reed Group LTD
3200 Cherry Creek South Drive
Suite 220
Denver, CO 80209-9848
(800) 347-7443, (303) 777-0515
Fax: (303) 871-0599

The Reed Group, LTD offers the Medical Claims and Case Management Solutions Conference at least twice annually. This conference is recommended for anyone who wants practical training on managing medical disability. Costs range from $795.00 to $895.00.

COLLEGE OR UNIVERSITIES WITH CASE MANAGEMENT CONTINUING EDUCATION, CASE MANAGEMENT MAJORS OR GRADUATE LEVEL PROGRAMS

Barry University
11300 N.E. Second Avenue
Miami Shores, FL 33161
(305) 899-3900

Post-graduate certificate program in case management. Applicants must have bachelor's degree. Two courses offered each eight week cycle. Must complete six courses to receive certificate. Cost: $200.00 per course.

Baylor University School of Nursing
3700 Worth Street
Dallas, TX 75246
(214) 820-4191
Dr. Pauline Johnson

This university offers a graduate program with a focus on Patient Care Management. The successful graduate of this program will be capable of practicing professional nursing in either a complex or simple organizational setting, providing care to clients through efficient use of resources in a manner that diminishes fragmentation of care and enhances the quality of life. For further information, contact the university at (214) 820-4191.

Benedictine University
5700 College Road
Lisle, IL 60532

This university program offers a Managed Care Certificate Program. This 16-hour graduate level program is designed to provide an understanding of the entire U.S. healthcare system and its evolution to managed care. Courses taken in the Managed Care Certificate Program can be applied to a variety of graduate degree programs. For further information, contact the university at (630) 829-6200.

Carlow College
Division of Nursing
3333 Fifth Avenue
Pittsburgh, PA 15213
Tracey Kneiss, B.S.N., R.N.

This college offers a Case Management Certificate Program which provides the student with the knowledge and skills to manage complex patients and families in a variety of health care settings. For further information, contact the college at (412) 578-8764.

DePaul University
Department of Nursing
802 West Belden Avenue
Chicago, IL 60614-3214

This university offers a certificate program in Managed Care and Case Management. This certificate of advanced study is designed for individuals who are just beginning work within the case management system or would like to expand their knowledge base related to managed care systems. For further information, contact the university at (773) 325-7280.

Detroit College of Business
4801 Oakman Boulevard
Dearborn, MI 48126-3799
Carole Gdula, R.N., COHN-S

This college offers a bachelor's degree program in the field of case management. The program provides a body of knowledge encompassing the laws, public regulations and delivery systems related to case management. For further information, contact the college at (313) 581-4400.

Johns Hopkins University
School of Nursing
1830 North Charles Street
Baltimore, MD
(410) 955-7548

Two year master's program in nursing. Applicants must complete 60 credits. Cost: $677.00 per credit.

Lynn University
3601 North Military Trail
Boca Raton, FL 33431
(561) 994-0770

Post-graduate certificate program in case management. Applicants must have bachelor's degree. Certificate requires a total of 18 course credits and three credits for 500 hours of internship. Courses offered in the evenings. Cost: about $300.00 per credit hour.

Pacific Lutheran University
School of Nursing
Tacoma, WA 98447-0003
Celo Massicotte Pass, R.N., D.S.N.

This university offers a graduate program in the field of case management. The process oriented curriculum prepares the student to be successful in the practice of case management in a variety of practice settings. For further information, contact the university at (253) 535-8872.

Samuel Merritt College
370 Hawthorne Avenue
Oakland, CA 94609
(510) 869-6576

Thirty-month post-professional master's program. Cost: $580.00 per credit.

San Francisco State University
School of Nursing
1600 Holloway Avenue
San Francisco, CA 94132
Charlotte Ferretti, R.N., Ed.D.
Mary Ann Haw, Ph.D.

This university offers a master's program in case management. This program prepares nurses for leadership roles in case management/long term care in acute care, ambulatory care and community and home health settings. For further information, contact the university at (415) 338-2371.

Sonoma State University
Nursing Department
1801 East Cotati Avenue
Rohernt Park, CA 94928
(707) 664-2778

Master's of nursing in case management offered for applicants with bachelors in nursing and RN license. Also, post masters certificate in case management open to non-nurses. Master's program takes five semesters with six to seven credits per semester at a cost of $180.00 per credit. Certificate program takes three semesters and a total of 13 to 21 credits depending on applicant's master's program.

State University of New York
Brooklyn College of Nursing
Box 22
450 Clarkson Avenue
Brooklyn, NY 11203-2098
Dr. Laila Sedhom

This university offers a master's program in nursing with a significant component in either continuity of care related to the adult or the pediatric patient. For further information, contact the university at (718) 270-7605.

Texas Gerontological Consortium for Continuing Education
Elees@utsph.sph.uth.tmc.edu.

25 community colleges that offer a 60 hour certificate program in case management with focus on long-term or elderly care management. Most applicants have bachelor's degrees, but it is not a strict requirement. Applicants must complete field experience in addition to course work. Cost: varies by institution.

University of Arizona
College of Nursing
P.O. Box 210203
Tucson, AZ 85721-0203
www.nursing.arizona.edu
Pamela Reed, R.N., Ph.D., FAAN

This university offers a master of science degree which will prepare you to practice as a professional Nurse Case Manager (NCM), an evolving and advanced form of nursing practice. For additional information, contact the College of Nursing Information Center at (520) 626-6154.

University of Melbourne
School of Post Graduate Nursing
Faculty of Medicine, Dentistry and Health Sciences
243-249 Grattan Street
Carlton, Victoria, Australia 3053
61-3-9344-8811
Fax: 61-3-9347-4172
m.feigl.@nursing.unimelb.edu.au.
www.medfac.unimelb.edu.au/nurse.

Graduate diploma in case management offered by Internet. Applicants must have a bachelor's degree in an appropriate field. Course includes six subjects of 12 weeks duration each. Course takes about 18 months to complete.

University of Saint Francis
500 Wilcox Street
Joliet, IL 60435
Tom Whitgrove

This university (formerly College of St. Francis) offers Certificates of Training in Basic and Advanced Case Management. These modules include: Introduction to Managed Care; Introduction to Case Management; Introduction to the Case Management Process; Legal and Ethical Issues; Conflict Management and Negotiation and Utilization Management and/or Cost Benefit Analysis and Case Management Outcomes. Any of these programs can be tailored to meet the particular needs of an organization, and can be presented at the work-site, at a nearby facility, or at the University's Illinois campus. For further information, please contact the university at (815) 740-3520.

University of San Diego
Hahn School of Nursing 5998 Acala Park
San Diego, CA 92110-2492
(619) 260-4548

Offers two year master's program in nursing. Applicants must complete 40 credits. Cost: $555.00 per credit.

University of Virginia
School of Nursing
McLeod Hall
Charlottesville, VA 22903-3395
Sharon Utz, Ph.D., R.N.

This university offers an Adult Health Nursing MSN track and a post-master's certificate program to prepare nurses for advanced practice roles in the care of adults with chronic conditions across the continuum of inpatient and outpatient settings. The major focus is developing clinical expertise as a foundation for roles such as case manager or clinical nurse specialist, teacher, researcher, consultant and clinical leader. For further information, contact the university at (804) 924-2743.

Vanderbilt University
Vanderbilt School of Nursing
461 21st Avenue, South
Nashville, TN 37240
(615) 322-3800

Master's of nursing offered. Applicants with bachelor's in nursing must complete 39 credits. Applicants with bachelors in other field must complete a total of 85 credits. Cost $643.00 per credit.

Villanova University
College of Nursing
800 Lancaster Avenue
Villanova, PA 19085
Dr. Claire Manfredi

This university offered the first graduate program to prepare nurses for a practice in Case Management. The current program offers nurses an opportunity to prepare for an advanced practice in Case Management. For further information, contact the university at (610) 519-4907 or e-mail Dr. Manfredi at Cmanfred@Email.vil.edu.

RESOURCES

GLOSSARY OF CARE/CASE MANAGEMENT

Accountability – Being responsible as healthcare professionals for actions and judgments involved in patient care.

Advocacy – The assistance provided clients and their families in accessing quality care and services, both in VA and the community. It includes identifying gaps in services throughout the continuum of care; assisting in the planning, development and delivery of these services; considering ethical issues in patient care; and ensuring that the client's needs, preferences, and rights are preserved.

Assessment – A comprehensive subjective and objective evaluation of a person's physical, psychological, social, and functional status.

Biopsychosocial – That which encompasses the physiological, psychological, and social aspects of an individual.

Conflict Resolution – A process that identifies conflict among parties and implements strategies to resolve the conflict.

Delegation – The act of appointing a person to act as one's representative or agent in a specified manner.

Developmental Theory – A concept that outlines the emotional, intellectual, and social changes that occur across the life span of human beings.

Family – Individual(s) may be immediate blood relatives, significant others, non-familial care providers, and/or the client's informal support system.

Goal – A statement of a desired future state, condition, or purpose.

Functional Status – Assessing the well-being of a person using the components of physical functioning, physical limitations in role functioning, bodily pain, general health, vitality, social functioning, role limitations due to emotional problems, and mental health. In the Veterans Health Care System, this is measured by the SF-36V, a brief patient-centered questionnaire.

Interdisciplinary Team – A group of care providers whose care reflects their collaborative efforts to address patient care needs. The team maintains common goals and discipline efforts but also encompasses interactions between members of the team. The collaborative nature of relationships reflects the dynamics that distinguish between the interdisciplinary team from the multidisciplinary team.

Interventions – Any action that is intended to interrupt or change events in progress. Any action taken to modify the health of an individual or group. The intervention may pertain to disease prevention, detection, diagnosis, or management.

Mediation – An attempt to bring about a peaceful settlement or compromise between disputants through the objective interventions of a neutral party.

Multidisciplinary Team – A team which functions to achieve common goals and requires the individual efforts of members from various disciplines to achieve team goals. Members from each discipline bring specialized knowledge and skills to the team to address client needs.

Negotiation – The process of bargaining that precedes an agreement.

Outcomes – In health care, the cumulative result at a defined point in time due to the performance of one or more processes in the care of the client. The result of an action. A measurable change.

Patient Centered Care – One type of model of healthcare delivery, which involves a paradigm shift from a provider, oriented system to a patient oriented healthcare system through the redesign of patient care delivery. Resources and personnel are organized around the patient's healthcare needs. Patient centered care incorporates the concepts of preventative health, customer service, cost management and quality of life by streamlining healthcare under the umbrella of a primary care provider team. Common elements associated with patient centered care include significant decentralization of services, cross training of personnel, establishment of interdisciplinary work teams, use of protocols and patient and staff empowerment.

Primary Care – Integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs. It is characterized by four key factors: accessible first contact care, continuity over time, comprehensiveness, and coordination.

Team – A cohesive group that functions to achieve mutually identified goals.

Transdisciplinary Team – In the transdisciplinary team, common goals, individual and discipline efforts and cross-discipline interactions are maintained. Interactions between related disciplines transcend discipline boundaries. Team members share tasks that are routinely reserved for other disciplines. Discipline boundaries do not limit patient interactions with individual team members.

HELPFUL VIDEOTAPES FOR CARE/CASE MANAGERS

1. **MDS 2.0 Resident Assessment and Care Planning:**
   Program 1: The Assessment and Care Planning Process (32 min.)
   Program 2: Guidelines for Completing the MDS 2.0 (1 hr., 4 min.)
   Program 3: Procedures for applying the RAPs and Developing Care Plans (51 min.)
   Produced by Briggs Health Care Products. Des Moines, IA: Briggs Health Care Products, c1996.

2. **Role of the Case Manager (hospital-based case management, 26 min.)**
   Produced by Concept Media, San Luis Video Productions, Irvine, CA: Concept Media, c1996.

3. **"Asking the Questions: How Case Managers Can Guide their Client through the Comprehensive Assessment",** Produced by LTC Resource Center, University of Minnesota. Available in medical center libraries, catalog number ALLHCF WT 30 AQ835 1995.

4. **Care Management in VA: Coordinating Care Across All Settings** (13 min.) Produced by the Employee Education System. Available in medical center libraries, catalog number ALLHCF W84.7 C27A 1999.

5. **Care Management in VA: The Benefits, The Process, & The Required Skills, Knowledge and Competencies** *(series of three videotapes with print material)*, Produced by the Employee Education System. Available in medical center libraries, catalog numbers ALLHCF W84.7 C2711 1999, ALLHCF W84.7 C2712 1999 & ALLHCF W84.7 C2713 1999.

RESOURCES

The following material includes a limited number of references directly related to the VA Care/Case Manager role. As a supplement, selected references from Case Management literature are included to assist you with your program development. It is not the intention of the Task Force to endorse any of the referenced material.

CARE MANAGEMENT-BOOKS

Applebaum R, Austin C. *Long term case management: design and evaluation.* New York (NY): Springer; 1990. 179p.

The authors incorporate empirical data, reviews of demonstration projects, and analysis of specific service programs in the design, execution, evaluation and monitoring of case management. The chapter on case management design options addresses the interface between case management and the local service system, tasks and functions of case managers, staffing and professional issues, configuration of the program, authority of case managers, interface with the health care sector, caseload parameters. The second part of the book offers specific strategies for evaluating and monitoring case management. The third part of the book looks at the planning of case management and examines larger program, agency, etc. issues.

Austin, Carol D; Mc Clelland, Robert W, editors. *Perspectives on case management.* Milwaukee (WI): Families International; 1995. 288p.

Presents an overview of case management practice today. It addresses particular case management approaches tailored to several subpopulations, including HIV patients, severe mentally ill adults, adolescents and children, drug/alcohol treatment patients, etc. Eight independently authored chapters discuss development and current implementation of case management for these groups, current research on the effectiveness of case management, and ethical and training issues faced by practitioners. The authors include concise summaries of recent legislation and demonstration projects that have reconfigured case management practice.

Blancett SS, Flarey DL, editors. *Case studies in nursing case management.* Gaithersburg (MD): Aspen; 1996. 450p.

This book has 25 individually authored chapters on a wide range of case management topics. This book centers on the application of case management to a variety of patient cohorts and settings across the delivery continuum-from home to hospital to ambulatory clinic to subacute care setting to insurance company to community agency. The theory and concepts of case management are presented in the companion book, Handbook of Nursing Case Management.

Center for Healthcare Information. *The case management resource guide.* Irvine (CA): Center for Healthcare Information; 1998. 1,100p.

Described as having over 100,000 entries covering information about specific homecare, rehab, long-term care, behavioral health, specialty and disease management services. At a more detailed level you will find such entries as addiction treatment programs, self-help and voluntary organizations, etc. Since there are four volumes divided into geographical regions, the volumes can be purchased separately. A typical entry on a rehab facility includes contact information, credentials, programs, number of acute beds, admission requirements, special programs, special needs served other services.

Cesta T, Taban H. *The case manager's survival guide: Winning strategies for clinical practice.* St. Louis (MO): Mosby; 1997. 200 p.

The authors present the "nuts and bolts" of case management including planning, implementation, and evaluation of successful case management programs. They also examine the case manager roles and skills, the case management process of patient care, training, education, credentialing and certification of case managers. A nice feature of this book are the "Tips Boxes" which list important tools and techniques to be used on the job. The publishers of this book describe it as an "at hand" consultant.

Cohen EL, editor. *Nurse case management in the 21st century.* St. Louis (MO): Mosby; 1996. 274p.

Leaders in case management offer their opinions on Nursing's Contribution to Restructuring Health Care in Part 1 of this book. Part 2 centers on Creating a Foundation for Change including a chapter by Gerri Lamb on Case management in Community Nursing Centers as well as The Education of Nurses: Nurse Case Managers' View by Mary Sinnen and Maria Schifalaqua. Part 3 on Partners in Health: Nurses and Clients and Part 4 is centered on The Nurse Case Management Process.

Cohen EL, Cesta TG. *Nursing case management: From concept to evaluation.* St. Louis (MO): Mosby; 1993. 239p.

Considered to be the first book to provide comprehensive data and insights on case management. It offers a broad basis to understand case management from the inpatient perspective as well as "beyond-the-walls". It offers chapters on the planning process, implementation and methods of evaluation for use by those involved in case management. In addition, there is a history of nursing case management, its relation to managed care, and a chapter on organized labor and case management.

Donovan MR, Matson TA. *Outpatient case management: Strategies for a new reality.* Chicago (IL): American Hospital Publishing; 1994. 298p.

Multi-authored book that ranges from discussion of case management issues in Part 1 to practical suggestions on implementing case management in specific areas including emergency care, hospice, ambulatory care, cardiovascular services and long-term care in Part 2. The experience of the authors is offered as a valuable resource to those using case management as a health care delivery system.

Flarey DL, Blancett SS. *Handbook of nursing case management: Health care delivery in a world of managed care.* Gaithersburg (MD): Aspen; 1996. 512p.

The theories, concepts and strategies of case management presented in this book will provide the reader with a solid foundation in this area. It is multi-authored and brings the leading experts together in one place. The topics range from managed care, capitation, integrated networks, and case management models to developing pathways, building interdisciplinary collaborative teams, assessing variance analysis, and educating and training case managers. Case Studies in Nursing Case Management by Blancett and Flarey bring the concepts and theories in this handbook to life.

Howe R. *Case management for healthcare professionals.* Chicago (IL): Precept Press; 1994. 218p.

The publishers describe this book as a highly detailed, logically organized presentation of case management in the context of state-of-the-art quality improvement techniques. Experts from across the United States have contributed to this innovative work. Experts offer practical information for every healthcare field: self-care, primary care, inpatient care, community and public health care, and more.

Howe R. *Medical case management: Forms, checklists and guidelines.* Frederick (MD): Aspen; 1995.

According to the publisher, this book highlights "human resources, self-care case management, primary care case management, episodic case management, rehabilitation case management, quality improvement and outcome evaluation, legal issues, reimbursement/financial issues, etc". This is a loose-leaf manual that will be supplemented annually.

Lamb G, Donaldson N, Kellogg J. *Case management: A guide to strategic evaluation.* St. Louis (MO): Mosby-Year Book, Inc; 1998. 256p.

In this book, the authors focus on evaluation of case management programs. The authors provide a step-by-step format to guide users through a systematic methodology that measures program worth, cost, quality of care, patient outcomes. Besides the necessary hands-on tools necessary for evaluation, they include literature readings, recommended references, summaries of case management evaluation studies and copyable forms and worksheets.

Mullahy CM. *The case manager's handbook.* Frederick (MD): Aspen; 1994. 432p.

This book is described has having the following features: "Proven-effective techniques for documenting the success of your work; hands-on methods that can be used by persons at all levels of expertise; many case studies and examples of case management in action; ideal for use as a training guide for new case managers." Practical information including the profile of a case manager and case management procedures as well as the administration and legal and financial considerations of case management. Trends and opportunities in case management are also included.

Newell M. *Using nursing case management to improve health outcomes.* Gaithersburg (MD): Aspen; 1996. 289p.

The author presents case management as both a clinical and business tool. He offers a broad overview of the various settings and forms of case management. The characteristics and requirements for effective case management are discussed as well as the links of case management to systems theory, continuous quality improvement methods, and to the documentation of health outcomes. The book is described as a "veritable toolbox for the would-be nurse case manager." The book is divided into three sections: Engaging the System; Engaging the Patient; and Engaging the Future. The section on engaging the patient is singular in books on case management. The appendix includes forms and tools, a glossary, and acronym dictionary.

Powell SK. *Nursing case management: A practical guide to success in managed care.* Philadelphia (PA): Lippincott-Raven; 1996. 392p.

This is a "how-to" book for case managers. The first part defines case management and looks at the necessary qualifications and responsibilities of the nursing case manager. The second part of the book reviews the basic concepts of case management while the third part focuses in detail on the case management process including the practicals from case screening to evaluation.

Quinn J. *Successful case management in long term care.* New York (NY): Springer; 1993. 157p.

The author discusses global topics such as aging in the United States and long-term care policy as well as specific issues. Information on guidelines, assessment, care planning, and evaluation are discussed. Issues related specifically to long term care case management are presented including nursing home placement, health problems and informal supports. The author reviews several case management practice models: the freestanding case management agency, special units, multifunction agencies, the consortium model, and an insurance case management model. Unfortunately, there is not a depth of discussion on these models.

Raiff N, Shore B. *Advanced case management: New strategies for the nineties.* Newbury Park (CA): Sage Publications; 1993. 190p.

Thoroughly examines innovative practices and innovations that have emerged in the late 1980s and early 1990s in case management. The authors focus on the identification of critical services and design variables. They offer a "metamodel" of case management that integrates traditional functions with cutting edge issues like cultural competence, consumer empowerment, clinical case management, and multidisciplinary practice.

Rothman J. *Guidelines for case management: Putting research to professional use.* Itasca (IL): Peacock Publishers; 1993. 127p.

The author has carefully examined the knowledge base of the field and offers generalizations and related action guidelines to aid in the design of case management interventions, the development of case management programs and the evaluation of the impact and effectiveness of case management. Even though this book does not examine specific case management models, it is a useful resource for health care providers if they want to design and implement a program on the knowledge base of the field. A final compendium summarizes specific action guidelines.

Satinsky MA. *An executive guide to case management strategies.* Chicago(IL): American Hospital Publishing; 1995. 132p.

This book is written to those who will conceptualize and establish case management within their health care settings as well as those who will perform the job of case management. The author moves from a discussion of the what, why and how of case management to discussion of the implementation of case management at four different health delivery systems including Malden Hospital, Friendly Hills HealthCare Network, Carondolet St. Mary's Hospital and Health Center, Sharp HealthCare and Lutheran General. Included are some useful resource guides including "Suggested Curriculum for Case Managers to Selecting a Consultant".

Siefker JM, Garrett MB, Van Genderen A, Weis M. *Fundamentals of case management: Guidelines for practicing case managers.* St. Louis (MO): Mosby; 1997. 280p.

This book focuses on insurance-based or external case management. More specifically, it acts as a guide in accident/health and property/casualty insurance including workers' compensation. The authors address cutting-edge issues such as the future of case management, disease management, risk management, telephonic vs. onsite case management, and vocational rehabilitation.

St. Coeur M, editor. *Case management: Practice guidelines.* St. Louis (MO): Mosby. 1996.

The publisher describes this book as follows: "The first part provides an overview, followed by case management considerations and generic guidelines including primary diagnosis, referral triggers, goals and long-term care. The second part presents specific case management guidelines for several major disease/injury states. ... Suggestions, critiques and recommendations were solicited from more than 300 case management specialists."

Surber RW, editor. *Clinical case management: A guide to comprehensive treatment of serious mental illness.* Newbury Park (CA): Sage; 1994. 275p.

Focuses on issues created by serving those with serious mental illness through the use of case management. A section on clinical case management themes includes chapters on clinical case management as an approach to care and the engagement of families and members of informal support systems. The traditional functions of assessment, treatment planning, linkage, and advocacy are addressed in section two. The third section covers a range of specific treatment issues including

substance abuse, working with people who present personality disorders, intervening into problematic behaviors, and supporting client goal attainment. Unfortunately, there is no discussion of case management as an alternative to inpatient commitment, or the interface between case management and the criminal justice system.

Zander K, editor. *Managing outcomes through collaborative care: The application of care mapping and case management.* Chicago: Am Hospital Publishing; 1995. 220p.

Emphasizes the relationship between formalized collaborative processes and the management of outcomes through the use specifically of caremaps and case management models. This book offers a historical perspective as well as up-to-date strategies to implement clinical pathways and case management by focusing on the central issues involved with these processes. A practical book.

CARE MANAGEMENT-RELATED RESOURCES

Buffum M, Dean H. (eds.) *Toward enhanced outcomes measurement: An outcomes measurement reference book.* Washington (DC): U.S. Department of Veterans Affairs, Nursing Service, Research Constituency Center, June 1996.

Duffy D, Englehart J, Evan RL, Franciose JP, Raber S, Romeo MA, Van Horn E, Wardlow-Brown D. *Case management outcomes & measures: A social work source book.* Washington (DC): National Center for Cost Containment, U.S. Department of Veterans Affairs; 1997, 174p.

Fantle, L. A., (ed.) *Case Manager's Desk Reference.* Gaithersburg, (MD): Aspen Reference Group, Aspen Publishers, Inc., 1999.

Agolino S, Brake SJ, Cooley KD, Demong SE, Goldson MA, Krause RL, Sperandeo JA, Van Horn E. *Social work service practice guidelines, number 2.* Washington (DC): National Center for Cost Containment, U.S. Department of Veterans Affairs; 1995.

Jacobs, MD, Nelson A, Berrio MW. (eds.) *Outcomes Assessment Tools.* Washington (DC): U.S. Department of Veterans Affairs, Nursing Research Constituency Center; 1998.

Zimmerman DL, Daley J. *Using outcomes to improve health care decision making.* Primer Series. Boston (MA): Management Decision and Research Center (MDRC); 1997

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CARE MANAGEMENT-PERIODICALS

Subscription prices may have changed.

Case Management Advisor
American Health Consultants
3225 Piedmont Road, NE
Building Six, Suite 400
Atlanta, GA 30305
1-800-688-2421
$299 (12 issues)

The Case Manager
Mosby-Year Book, Inc.
11830 Westline Industrial Drive
St. Louis, MO 63146
1-800-453-4351
$43 (6 issues)

Case Review
Allied Health Care Publications
4676 Admiralty Way
Suite 202
Marina del Rey, CA 90292
310-306-2206
Free

Continuing Care
Stevens Publishing Company
5151 Beltline Road, Suite 1010
Dallas, TX 75240
972-687-6700
$99 (10 issues)

*Home Care Case Managemen*t
American Health Consultants
3225 Piedmont Road, NE
Building Six, Suite 400
Atlanta, GA 30305
1-800-688-2421
$347 (12 issues)

Hospital Case Management
American Health Consultants
3225 Piedmont Road NE
Building Six, Suite 400
Atlanta, GA 30305
1-800-688-2421
$359 (12 issues)

Inside Case Management
Aspen Publishers
7201 McKinney Circle
Frederick, MD 21701
301-417-7500
$99 (12 issues)

Issues and Outcomes
Center for Case Management
6 Pleasant St.
South Natick, MA 01760
1-508-6551-2600
$160 (6 issues)

The Journal of Care Management
Mason Medical Communications, Inc.
PO Box 210
Greens Farms, CT 06436-0210
203-259-9333
$40 (6 issues)

The Journal of Case Management
Springer Publishing
536 Broadway
New York, NY 10012
212-431-4370

The New Definition
Published by the Center for Case Management
Center for Case Management
6 Pleasant St.
South Natick, MA 01760
1-508-6551-2600
Free

Nursing Case Management: Managing the Process of Patient Care
Lippincott-Raven Publishers
12107 Insurance Way
Hagerstown, MD 21740
1-800-777-2295
$46 (6 issues)

Outcomes Management for Nursing Practice
Lippincott-Raven Publishers
12107 Insurance Way
Hagerstown, MD 21740
1-800-777-2295
$51 (4 issues)

Team Rehab Report
Miramer Communications, Inc.
23815 Stuart Ranch Road
Malibu, CA 90265
310-317-4522
$36 (6 issues)

Workers' Compensation Law Bulletin
Quinlan Publishing Co.
23 Drydock Avenue
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CARE MANAGEMENT-ADDITIONAL SOURCES OF STANDARDS

National Association for Social Workers
750 First St., NE
Suite 700
Washington, DC 20002
1-800-227-3590
National association for social workers' case management standards, June 1992
First copy is free; $25/100 copies

American Nurses Association
600 Maryland Avenue, SW
Suite 100W
Washington, DC 20024
1-800-274-4262
No Case Management Standards available as such but do have *ANA nursing standards* for Acute Care Nurse Practitioner; Addictions Nursing; Administrators; Advanced Practice; Cardiac Rehab; Clinical Nursing; Community Health; Gerontological; Home Health; Oncology; Otorhinolaryngology; psychiatric-mental health; respiratory.
cost varies

National Association of Rehabilitation Professionals in the Private Sector
1661 Worcester Road
Suite 203
Framingham, MA 01701
1-508-820-8889
Professional performance criteria for medical case management
available on the Internet http://narpps
free

National Association of Professional Geriatric Case Managers
1604 N. Country Club Road
Tucson, AZ
1-520-881-8008
Professional geriatric case management standards
free

CARE MANAGEMENT INTERNET RESOURCES

CMSA Online
http://www.cmsa.org/
The online service of the Case Management Society of America offers a huge amount of disease-, condition-, and management-specific information. Features include: educational forums; databases; communications (includes live online conferences; links to useful sites).

The Center for Case Management
http://www.cfcm.com/
This site describes the services and products of this consulting firm as well as announces the seminars, conferences and publications available from them. Links to a few sources for automating clinical pathways is also available.

Case Management Resource Guide
http://www.cmrg.com
This site offers a free searchable database of over 110,000 specialty healthcare services, facilities, businesses, products and organizations. There are 40 categories of healthcare services and resources including homecare, rehabilitation, subacute care, etc. It also includes over 2,000 health organizations, self-help groups, government agencies and clearinghouses that provide information or support resources for patients and their families. CEU courses for case managers and disease management resources are also available.

Health Finder
http://www.healthfinder.gov
Healthfinder is a gateway to consumer and human service information from the United States government. Included are: on-line publications, clearinghouses, databases, other web sites, support and self-help groups, and government agencies.

Medscape
http://www.medscape.com
Medscape provides online clinical information including more than 400 full text peer reviewed articles, annotated links, announcements by topics, archived literature searches, daily news in healthcare. In addition, there is a show-and-tell for clinicians with case histories, questions to address and a discussion of the diagnosis.

RxList
http://www.rxlist.com
RxList is a searchable index of drugs. The description, action, use, contraindications, warnings, cautions, drug-drug interactions, side effects, toxicity, and dosing for each drug is listed. There is also a listing of the top 200 prescribed drugs by rank or alphabetically.

Health Information Research Unit
http://www@hiru.mcmaster.ca
This site, supported by McMaster's University, is dedicated to studying health information, developing information tools to support evidence-based care, and evaluating informational health interventions.

Healthgate
http://www.healthgate.com
Health, wellness and biomedical information is offered at this site. Features included are:
Front Desk, Health Center, MedGate, Healthy Living, Free pages, Medicine, Drug Information, Patient Education and free searching of Medline, Cancerlit and other databases. It is an interactive health information service offering a community support group for people with chronic or acute conditions.
Unfortunately there is a fee for much of the material.

Medical Matrix
http://www.medmatrix.org/index.asp
This is a peer-reviewed site that offers an extensive database of medical resources. The general categories of resources are: Specialty and Diseases; Clinical Practice; Literature; Education; Healthcare and Professionals; Computers, Internet and Technology; Marketplace; Medline, Journals, CME, News, Rx Assist; Textbooks; Forums and Patient Education.

PharmWeb: Pharmacy Information on the Internet
http://www.pharmweb.net
The features on this large site include: PharmSearch, PharmWeb, World Drug Alert, PharmWeb Discussion Forum, Patient Information, PharmWeb Directory of People in the Health Professions, PharmWeb Yellow Pages, Academic Institutions on the Internet, Government and Regulatory Bodies, Societies and Groups, Special Interest Pages which link to other sites with information on drugs and health, and a practical source on how to find information on the Internet with the common problems encountered using Web browsers.

Further Resources
Flory, J (ed). 1999 *Healthcare guide to the internet.* Santa Barbara (CA): COR Healthcare Resources;1999. $128. 1-805-564-2177.

Hoben JW (ed). *Healthcare WEB site directory.* New York (NY): Faulkner & Gray; 2000. $285. + $5. shipping. 1-212-967-7000.

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VA CONNECTICUT HEALTHCARE SYSTEM

CARE MANAGEMENT PROGRAM PLAN FOR DESIGN & IMPLEMENTATION

CARE MANAGEMENT PROGRAM PLAN FOR DESIGN & IMPLEMENTATION

Strategic Premise

A comprehensive Case Management Program is being proposed to: (1) effectively manage the provision/coordination of care across the continuum; (2) identify care and case management responsibilities and matrix to eliminate costs associated with inefficiency and/or duplication of services; and (3) increase value by improving quality of care while maintaining or reducing cost.

Outpatient-based case management will decrease unnecessary use of expensive tertiary services, and through health maintenance, health promotion and prevention strategies decrease acuity of illness in at-risk populations. Expected and actual outcomes include decline in use of tertiary services and a healthier population; both of which translate into a decreased cost of care (per covered life). This focus is consistent with goal identified in the document VA Wide Goals and Objectives to Accomplish VHA Managed Care Vision and Strategy.

Inpatient-based Patient Care Coordinators, in collaboration with the case manager and interdisciplinary team, will facilitate inpatient care from admission to discharge. In a managed care and fixed reimbursement environment this ensures necessary expenses are expended appropriately and efficiently and minimizes unnecessary expenses. Outcomes include appropriate utilization of inpatient resources, decreased length of stay (LOS) and decreased cost per discharge.

A Centralized Pre-Admission/Testing Area with an admissions coordinator, who is part of the case management team, will enhance the case management program. Implementing alternate levels of care including observation status (for pre-procedure care needs or for medically unstable patients who do not meet inpatient admission criteria) and an admissions process will promote quality of care, address performance measures and ensure appropriate level of care at the appropriate time in the most appropriate setting.

Definition of Case Management

Conceptual

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes as defined by the Commission for Case Manager Certification. Patients will be identified for case management either by the complexity of their care or their potential or actual high resource utilization. Patients may be carried for short-term intervention, or, in a small percentage of patients, for long-term one-on-one management.

Operational

Case management is used to maximize the contributions of the interdisciplinary health care team by minimizing fragmentation and facilitating the movement of the patient/family through the continuum. This process is designed to achieve optimal health care outcomes, while meeting the needs of patients, families, providers, and payers. Identified patients and/or certain populations of patients within the community, who may or may not be enrolled in specialty VA or community based program(s), are

managed by a qualified registered nurse and/or social worker. The case manager is a core member of the primary health care team. The case manager:

- Coordinates patient services and ensures that they are appropriate, consistent and timely;
- Manages both under and over utilization of resources;
- Provides an appropriate and timely continuing care plan;
- Provides a liaison relationship between providers, consulting services, community hospitals, agencies and facilities; and
- Actively facilitates the resolution of complex health-related problems.

Case Manager Role (Outpatient/community based)
Case managers are outpatient (community) based, will be especially prepared registered nurses or social workers with a minimum preparation of bachelor's degree with a master's degree preferred (incumbents will be grandfathered). Case managers must have current clinical competence, knowledge of the health care system, knowledge of the community and its resources, an excellent understanding of the rights and responsibilities of patients and their families, an ability to see the "big picture", and effective communication skills. Communication skills are a key component of the role; negotiation, collaboration and conflict resolution are daily activities. The case manager must provide leadership that demonstrates an understanding of and respect for the contributions made by all members of the health care team.

The case manager will manage a population of patients who are potential or actual high users of health resources across the health care continuum or have an event of care requiring case management services. Case Managers engage in assessment, coordination, planning, monitoring, implementation and evaluation and applies these to coordination and service delivery, physical and psychological factors, benefit systems and cost analysis, case management concepts and community resources. In addition, the case manager practices within the full continuum of care encompassing multiple environments requiring continuing involvement with all parties dealing with the individual's broad spectrum of needs. The caseload will be predominantly an outpatient population who may have an intermittent need for inpatient care and consultative services.

Patient Care Coordinators (Inpatient/episode-based coordination)
A Patient Care Coordinator is a specially trained registered nurse with a minimum preparation of a bachelor's degree (incumbents will be grandfathered) that coordinates the inpatient episode of care for patients on a specific unit(s). They must have current clinical competence, knowledge of the health care system, knowledge of the community and its resources, an excellent understanding of the rights and responsibilities of patients and their families, an ability to see the "big picture", and effective communication skills. Patient Care Coordinators oversee clinical coordination of care from admission to discharge and also provide leadership that demonstrates an understanding of and respect for the contributions made by all members to the health care team,

Goal and Objectives

Short term
- Improve health care processes and outcomes for hospitalized patients
- Decrease LOS for the hospitalized population
- Decrease the re-admission rates of the hospitalized population
- Improve continuity of care throughout the health care system
- Reduce duplication of services
- Increase reimbursement to VACT through MCCF for acute hospital days

- Improve health care team member satisfaction
- Improve patient satisfaction
- Increase and improve the effectiveness of interdisciplinary collaboration
- Enhance access to appropriate VA and community resources
- Develop operational links between various complimentary providers within VA Connecticut and providers in the community such that an effective continuum is in place

Long Term

- Reduce the use of tertiary services
- Demonstrate a measurable improvement in the clinical outcomes of patients/community
- Channel/enroll veterans from the community into VA CT Healthcare System for primary care (including C80Cs).
- Develop a product (for selected populations) that can be marketed to managed care companies (on a fee-per-covered life or service basis)

Caseload Design Plan

Patient Care Coordinators are inpatient based and assigned to acute care medical and surgical units. Case Managers are outpatient based and are assigned by health problem (disease) and/or firm. The inpatient collaborative role of the Case Manager's caseload will be firm and campus specific, with the exception of special consults.

FTE Allocation:

Inpatient Patient Care Coordination Assignments (5)

	Present staffing:	**Recommended staffing:**
Surgery	G4E (1) SICU/SSDU (O)	1 .5 additional .5
Medicine	G4W (1) G5W (1) MICU/MSDU (O)	1 1 .5 additional .5
Leavetime (O)		1 additional 1.0
		Total Additional Staff: 2.0
Psychiatry	G8W (1)	0 - (due to team structure on G8W, recommend transition role to outpatient Case Manager position; PCCs will be based on acute care medical surgical units only)

Community Case Management Assignments (8)

Present staffing:	Recommended staffing:
Primary Care - West Haven campus (2)	4 additional 2.0
Primary Care - Newington campus (1)	3 (2 positions posted)
Specialty services (Oncology/Renal/Pulm/)	
Cardiology/Women's Clinic	(.4) 1 will increase w/ G8W PCC transferring to CM
Psychiatry (.2)	1 (PCC transition to CM)
C80Cs- (.2)	1 additional .8
Geriatrics (.5)	0.5
Newington Campus Liaison (.5)	0.5
Program Assistant (.5)	1
Leavetime (0)	2 additional .2
	Total Additional Staff 3.0 + Additional Prog Assis 0.5

Operational Structure

Organizational Chart- *see proposed Case Management Matrix Chart (Attachment A)*

Model Components & Functions

- Case Management is a clinical support program reporting to AD/Patient Care Services (CNO), with case managers assigned to care lines who matrix with Program Director/Case Management.
- Case Managers will collaborate with Patient Care Coordinators and the interdisciplinary team as described above.
- Patient Care Coordination will be provided to all inpatients. Some patients will require minimal intervention (monitoring) and others will require intensive management services.
- Patient Care Coordinators will take responsibility for 1) planning and coordinating care with the multidisciplinary team, 2) transitional planning to the home setting and initiating appropriate referral 3) assessing and coordinating transitional planning for placements in settings other than the home, 4) aspects of resource and utilization management, 5) patient advocacy and 6) assuring patient/family education. All activities will be directed toward achieving the defined goals of the program.
- The Case Manager will manage a select population of patients in the community, using admission and discharge criteria, in order to ensure access to the appropriate services and manage chronic conditions in a proactive manner. Potential populations include: cancer and terminally ill patients, frail elderly, patients transitioning from nursing home care to home, renal dialysis patients, and patients with unstable diabetes, congestive heart failure, chronic obstructive pulmonary disease.
- Case Management services will be provided using admission and discharge criteria. Admission criteria should show measurable and objective reasons for referral and may include frequent unscheduled visits; frequent inpatient admissions; referrals from protective services; referral from providers for high risk

patients; patients receiving home care services on Fee Basis Home Care Program, Homemaker/Home Health Aide Program and Contract Nursing Home Program. Discharge criteria will revolve around specific goals set for the individual patient at the time of admission to case management and should be agreed upon by the treatment team, patient and case manager.

- Case Management services will be provided Monday-Saturday with on call services on Sunday and holidays. The need for on-call coverage during evening hours will be evaluated following full program implementation.
- The Program Director is responsible for identifying opportunities to improve systems issues that create barriers to achieving program goals.
- The Program Director will work closely (partner relationship) with Nursing, Social Work, Quality Management and MCCF.
- Patient Care Coordinators and Case Managers will use a wide variety of "tools" to effect desired outcomes. They include clinical paths, variance analysis, protocols/algorithms, risk assessment, admission and discharge criteria, and process/outcome measures.
- Criteria for evaluation will involve a specific plan to evaluate the effectiveness of the program i.e. number of unscheduled visits, functional measures (SF36V), patient satisfaction surveys and/or number of patients achieving discharge goals.
- Case management staff will require additional program assistant support with data entry and management training; and will be provided with office space and equipment including fax, copier and PC with network access.

Plan for Program Implementation

Strategies

- Regular communication with providers and firm teams
- Establish admission and discharge criteria for case management
- Ensuring competency of case management staff
- Obtaining provider input and feedback regarding program activities
- Communication with diagnostic care departments
- Communicate program accomplishments and opportunities for improvement on regular basis to management, service chiefs and product line managers
- Communicate new role and relationship to firm staff
- Regular communication forum with AD/Patient Care Services, Supervisors and directors of various VA programs and community based programs
- Collaboration with Nursing, Social Work, Quality Management and MCCF
- Develop meaningful data base

Time Line
The goal is to have the program fully operational by 10/99.

Plan for Evaluation of Program

Both subjective and objective data elements will be collected.

PROPOSED CASE MANAGEMENT MATRIX