Case/Care Management Guidelines

*These guidelines are proposed to provide a framework for assessment to facilitate both transitions between levels of care and communication among professionals and with clients.

*For purposes of brevity, the term client is used throughout these guidelines to describe the client and client system (or patient and family). The client system (or family), as defined by each client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the client’s informal support network.

Overarching Concepts

Engagement
- Maximize client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the client’s participation in the plan of care.
- Ensure client’s right to privacy and safeguard confidentiality when releasing client information.
- Affirm client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Ensure the client’s efforts to participate in the plan of care.

Collaboration
- Define multidisciplinary team participants.
- Build relationships with all team members, with the client at the center of the collaborative model.
- Communicate with other professionals and organizations, delineating respective responsibilities.
- Create awareness around points of accountability for receiving and sending care settings.
- Provide services within the bounds of professional competency and refer client as needed.

Strengths-based assessment
- Use respect and empathy in client interactions.
- Recognize client’s strengths and use those abilities to effect change.
- Help client use past effective coping skills and insights to manage current crises.
- Recognize and help resolve client’s difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors.
Assessment as an ongoing process
- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess client’s needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon the client’s needs during all phases of care.
- Assess effectiveness of interventions in achieving client’s goals.
- Communicate changes in assessment and care plan to the health care team.

Common Elements for Assessment and Intervention

Physiological functioning
- Assess client’s understanding of diagnosis, treatment options, and prognosis.
- Evaluate impact of illness, injury, or treatments on physical, psychological, and sexual functioning.
- Evaluate client’s ability to return to pre-illness or injury function level.

Psychosocial functioning
- Assess past and current mental health, emotional, cognitive, social, or behavioral concerns that may affect adjustment to illness and care management needs.
- Assess effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning.
- Determine with client which psychosocial services are needed to maximize coping.

Cultural factors
- Affirm client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess cultural values and beliefs, including perceptions of illness, disability, and death.
- Use the client’s values and beliefs to strengthen the support system.
- Understand traditions and values of client groups as they relate to health care and decision-making.

Health literacy and linguistic factors
- Provide information and services in client’s preferred language, using translation services and interpreters.
- Use effective tools to measure client’s health literacy.
- Provide easy-to-understand, clinically appropriate material in layperson’s language.
- Use graphic representations for clients with limited language proficiency or literacy.
- Check to ensure accurate communication using teach-back methods.
- Develop educational plan based upon client’s identified needs.
- Evaluate caregiver’s capacity to understand and apply health care information in assisting client.
Financial factors
- Assess client’s access to, type of, and ability to navigate health insurance.
- Evaluate impact of illness on financial resources and ability to earn a living wage.
- Provide feedback on financial impact of treatment options.
- Educate client about benefit options and how to access available resources.
- Assess barriers to accessing care and identify solutions to ensure access.

Spiritual and religious functioning
- Assess how client finds meaning in life.
- Assess how spirituality and religion affect adaptation to illness.

Physical and environmental safety
- Evaluate client’s ability to perform activities of daily living.
- Assess environmental barriers that may compromise the client’s ability to meet established treatment goals.
- Determine with client the appropriate level of care.
- Assess ability of family or other informal caregivers to assist client.
- Assess for risk of harm to self or others.

Family and community support
- Assess how client’s illness affects family structure and roles.
- Provide support to family members and other informal caregivers.
- Assess for, and help resolve, conflicts within the family.
- Evaluate risk of physical, emotional, or financial abuse or neglect, referring to community social services as needed.

Assessment of medical issues
- Patient Diagnosis
- Symptoms
- Medication List & reconciliation of new medications through out treatment
- Adherence assessment & intention

Continuity/Coordination or Care Communication:
- Specific clinical providers
- Date information sent
Example of Assessment & Coordination of Care
Communication Check List

**MEDICATION Assessment:**
- ✓ Be sure you cover all prescribed meds, over-the-counter medications and health/nutritional supplements
- ✓ Name of Medication
- ✓ Dose
- ✓ Route
- ✓ Frequency
- ✓ Next Refill

**Can the patient tell you:**
- ✓ Reason they are taking medication
- ✓ Positive Effects of taking medication
- ✓ Symptoms or side effects of taking medication
- ✓ Where does the patient keep their medication at home
- ✓ When is the next refill date for their medication
- ✓ How long will the patient need to remain on the medication

**Modified Morisky Scale **

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>MOTIVATION</th>
<th>KNOWLEDGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you ever forget to take your medicine?</td>
<td>Yes(0)</td>
<td>No(1)</td>
</tr>
<tr>
<td>2. Are you careless at times about taking your medicine?</td>
<td>Yes(0)</td>
<td>No(1)</td>
</tr>
<tr>
<td>3. When you feel better do you sometimes stop taking your medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sometimes if you feel worse when you take your medicine, do you stop taking it?</td>
<td>Yes(0)</td>
<td>No(1)</td>
</tr>
<tr>
<td>5. Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist?</td>
<td>Yes(1)</td>
<td>No(0)</td>
</tr>
<tr>
<td>6. Sometimes do you forget to refill your prescription medicine on time?</td>
<td>Yes(0)</td>
<td>No(1)</td>
</tr>
</tbody>
</table>

*SOURCE: CMAG 2006*
Hand off all assessments to the next level of care coordination

CONTINUITY / COORDINATION OF CARE:

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Does the patient have a primary care physician? (if appropriate) Send assessment information to PCP – Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y/N</td>
<td>Does the patient have a specialty physician, e.g. cardiologist? (if appropriate) Send assessment information – Date</td>
</tr>
<tr>
<td>Y/N</td>
<td>Does the patient have a psychiatrist or other mental health provider? (if appropriate) Send assessment information – Date</td>
</tr>
<tr>
<td>Y/N</td>
<td>Does the patient’s have an outpatient case manager who should be notified? Send assessment information – Date</td>
</tr>
<tr>
<td>Y/N</td>
<td>Ensure all transition services and care (medications, equipment, home care, SNF, hospice) are coordinated and documented – Date verified</td>
</tr>
<tr>
<td>Y/N</td>
<td>Ensure patient and care giver understand all information and have a copy of the care plan with them. – Date verified</td>
</tr>
</tbody>
</table>