CASE MANAGEMENT

Process into Practice
HINTS

• Prep Handbook- candidate and written
• Think globally
• Study Buddy
• Scenarios First
TESTING

- Handbook Review – Find textbooks on the case management process
- Multiple Choice
- Scenarios
- Timing
MULTIPLE CHOICE

• 2 hours for 110 questions (90 are scored and 20 are pre-test questions)
• Tests:
  • Recall- rote memory
  • Application- applying the case management process to the situation given
  • Analysis- under the best of conditions what is the best solution or evaluate the usefulness of the solution
SCENARIOS

• 5 Scenarios - 4 are scored - 1 is for pre-test
• Based on how you would handle the situation under ideal conditions
• Decision Making and Information Gathering
• Four Areas of Emphasis
  • Screening and Assessment
  • Planning
  • Care Coordination
  • Evaluation
ENTHUSIASM
DEFINITION

Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self determination.

ACMA 2002
The National Association of Social Workers defines case management as a method of providing services whereby a professional social worker assesses 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 client specific needs.

NASW 2007
SCOPES OF SERVICE

• Education
• Care Coordination
• Compliance
• Transition Management
• Utilization Management
EDUCATION

- Patient education – making informed decisions on health management
- Physician, Staff and Community Education
- Case manager continuing education
- Risk management
- Legal assistance and coordination
- Patient relations
- Ethical: beneficence, no malfeasance, autonomy, and fidelity (veracity)
CARE COORDINATION

- Screening and Identification
- Assessment
- Plan of Care
- Sequencing
- Communication
COMPLIANCE

• Local, state and federal regulations
• CMS rules for discharge planning
• State licensing regulations
• HIPAA
• The Joint Commission
TRANSITION MANAGEMENT

- Identification
- Community Partnerships
- Transition Coordination
- Follow-up
  - Outcomes management
  - Data management
UTILIZATION MANAGEMENT

- Medical Necessity
- Payer Interface
- Avoidable Days and Delays
- Denials and Appeals
- Pre-payment Review (MAC)
- Recovery Auditors
UTILIZATION MANAGEMENT

• ADD Identification and Management
• UR Medical Necessity/UM Coordination
• Pre-admission planning
• 3rd party Communication
• Level of care
• Status determination
• Appeals and Denial Prevention
ROI AND SAVINGS

• ROI
• Hard Savings- decreasing LOS or Cost per case
• Soft Savings- increased capacity- d/c from ED
• Case Management Interventions
• Data management
STANDARDS OF PRACTICE

- Accountability
- Professionalism
- Collaboration
- Care Coordination
- Advocacy
ACCOUNTABILITY

• Recognizes the decisions made are based on patient choice and best practice in collaboration with the health care team and the patient.

• Integral team member for multidisciplinary rounds.

• Maintains network of colleagues

• Takes responsibility for all actions and follows through on their commitments.

• CM accountable for on-going education and development.
PROFESSIONALISM

• Aligns goals with the organization's goals, mission and vision
• Maintains licensure and certification
• Adheres to professionals standards
• Commitment to the profession of case management
• Sets goals for personal and professional development
• Realizes the need for mentorship with new staff and assists in training.
COORDINATION

• Education of patient and family about discharge, choice, and plans
• Involves community agencies when indicated
• Looks beyond the hospital discharge for coordination of care in the community.
• Incorporates expectations of the patient and the health care team for discharge
• Identifies multi-facets of the patients ability to participate and expected outcomes
ADVOCACY

• Promotes the right of self-determination
• Education on benefits, risks, financial responsibilities
• Alternate plans for discharge, choice of discharge.
• Evaluates the efficacy of the community services, SNFs, Home Health and other agencies directly involved in the patients care
• “No decision about me without me”
FACILITATION

• Early development of assessment and primary plan
• Early involvement of patient and family in the planning process and identification of a spokesperson, POA.
• Removes barriers for effective and safe discharge
• Fosters teamwork and team development for initiation of steps towards discharge.
PRACTICE INTEGRATION

- Daily processing
- Discharge planning
- Utilization Review
- Community Resources
- Caring for the under & uninsured
- Negotiating
- Prioritizing
RESOURCE MANAGEMENT

• Cost of care: impact on the patient, financial impact of their decisions for post acute care. Hard savings

• Manages costs through proper identification of tests, duplication of services and high cost diagnostics,

• Manages LOS: progresses patient through the inpatient stay for optimal care within the optimal time.

• Prevents readmissions through proper education and partnering with the payer and/or community resources for disease management. Soft savings

• Community resources and agencies to keep patient in the community and involved in care in the outpatient setting.
END OF THE DAY

• High patient satisfaction

• Best outcomes for the patient and family

• Safe, appropriate, and timely discharge

• Proper use of resources

• Partnership with community resources

• Regulatory Compliance
CASE MANAGEMENT PROCESS

- Case Finding
- Screening
- Assessment
- Planning – fluid-ongoing
- Execution
- Case closing and evaluation
TOOLS

• **Communication**: written and verbal/non-verbal

• Proper assessments with accurate documentation

• **Written communication should tell the story to all partners of care**

• Patient and family information and updates
SCREENING AND ASSESSMENT

- Communication/ types of Questions
- Barriers to Communication
- Cultural Diversity and Respect

“How well we communicate is determined not by how well we say things but how well we are understood”
- Andee Grove, Co-founder of Intel
INFORMATION SOURCES

- Patient
- Family
- Medical Record
- Physician
- Interdisciplinary teams
- Current community care providers
- Third Party Payers
- Clergy/Neighbors/Caregiver
SCREENING

- Cognitive
- Diagnosis/Medical Conditions
- Medications/Compliance
- Care Access/Financial Barriers
- Functional Status
- Social Situation
- Nutritional
- Emotional
  - Unbiased observations
ASSESSMENT

- Health Behaviors
- Response to illness
- Spiritual/Value system
- Past medical history
- Functional status
PSYCHOSOCIAL ASSESSMENT

- Body Image concerns
- Coping Skills
- Pain assessments
- ADL performance
- Occupation
- Self-care assessments
- Environmental concerns
- Housing and transportation concerns
- Family support
• Unbiased observations
• Family members
• POA/Decision Maker
• Barriers to planning
• Initial Plan of Care
• Advance Directives
• Resource availability
• Care Team Information
• Patient doing well after HIS hysterectomy
• The patient was alert and non-responsive
• Bleeding started in the rectal area and continued all the way to Los Angeles
• The test indicated abnormal lover function
• Patient was in his normal state of health until his airplane ran out of gas and crashed
• Both breasts are equal and reactive to light
PLANNING

- Smart
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Timely
PLANNING

• Patient centered
• HIPAA/Hi-tech HIPAA
• Continuity of Care
• Availability of Resources
• Medical Team as Coach
• Family involvement and agreement
• Documentation for communication to the team
REFERRALS AND RESOURCE MANAGEMENT

• Expected outcomes of resource management
• Identifying Available Resources
• Resource consumption/benefit analysis
• Negotiation with payer
• Quality of resources available
• Vendor availability
CARE COORDINATION

• Relationships:
  • Nursing/Social Workers
  • Physicians
  • PT/OT/Speech
  • Internal Hospital Systems
  • External Systems
  • Patient/Family

  “Pace the Case”
CARE COORDINATION OUTCOMES

• Health care dollars are saved
• Proper use of resources
• Timely and appropriate care
• Case Management is the driver of cost containment and patient’s right to self-determination.
• Prevention of abuse, fraud and waste through proper care coordination.
• Uses the strength of all the team members to develop plan of care and keep the patient at the forefront of the plan of care
REGULATORY ISSUES

• Abuse and neglect adult and children
• Legal requirements
• Ethical Considerations
• Patient self-determination act
• Health Care Decision Act
• Joint Commission
• CMS
REGULATORY ISSUES

• Mental Health Parity Act
• Medicare 1965: Medicare A, B, MA Plans, Part D
• Medicaid Title XIX
• HIPAA
• Release of Information
  • Mental Health Issues
  • HIV/AIDS
• Communicable Diseases
MEDICARE COVERAGE

• Medicare Part A
  • Inpatient care- acute, LTAC, Inpatient rehab
  • Hospice
  • SNF
  • Home Health

www.medicare.gov
DISCHARGE PLANNING

- Medicare Regulations
- Screening
- Elements
- Documentation
- Auditing
MEDICARE

- Determination of Status within 24 hours
- Conditions of Participation
- Acute Days versus SNF days
- Rules for placement
- Caveat of available days
  - Spell of illness
- Lifetime days -60
ESRD

- Hemodialysis
  - 3 months

- Peritoneal Dialysis
  - Self-care and home - one month (part B)

- Transplant
  - 3 years

www.medicare.gov/esrd

http://www.medicare.gov/Pubs/pdf/10128.pdf (pts booklet)
MEDICARE

- Code 44 Inpatient to Outpatient
- ABN/ HINN Letters/ Appeals
- IMM/ OBS letters
- Documentation
LETTERS

- HINN 10 – organization requests a review
- HINN 11 – given when a given procedure or test is not covered during a covered stay
- HINN 12 – given after an appeal
- ABN – usually given in the OP area
MEDICAID

• Eligibility
• Rules of Participation
• Waivers/Definitions
• Placement
• ESRD
TWO MIDNIGHT RULE

- Payment Rules
- Documentation
- Timing of care
- Start of inpatient care
- Delays in care
SPECIAL CIRCUMSTANCES

Two midnight rule exceptions:

- Inpatient only list
- Unforeseen beneficiary’s death
- Unforeseen transfer
- Beneficiary leaving AMA
- Unforeseen clinical improvement
- Inpatient hospice
REQUIREMENTS

• Physician Certification
  • Order authentication
  • Reason for admission spanning more than 2 midnights – co-morbid conditions, disease process, etc
  • Estimated time of hospitalization
  • Plans for post-hospital care
  • Inpatient starts when order is written, dated, timed and signed and prior to discharge.
MAC, RA, & HEAT

- **MAC- Medicare Administrative Contractors**
  - Function as Medicare oversight and payment
- **Recovery Auditors**
  - Act as review coordinators to assure the appropriate care has been administered and no over or under payment has occurred
- **HEAT Task Force FBI and OIG oversight**
BENEFITS OF ACO

• High Quality Clinical Care
  • Patient Centered Care - care coordination

• Competitive - greater efficiencies

• Patient Experience
  • Higher satisfaction, improved outcomes

• Financial
  • Better margins, sustainability
## Bundled Payment Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Episode</th>
<th>Services included in the bundle</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>All acute patients, all DRGs</td>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Model 2</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Model 3</td>
<td>Selected DRGs, post-acute period only</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Model 4</td>
<td>Selected DRGs, hospital plus readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

ACO ELEMENTS

- Proper screening and assessment
- Disease Management
- Care Coordination – network providers
- Resource Management
- Outcomes Management/Data Management
- Communication
ACO TRANSITION PLANNING

• Thinking beyond the walls

• No longer discharge planning - transition planning

• Patient centered care

• Inpatient and outpatient closely aligned
ADVANCED PLANNING

• Advanced Care Planning
• Advanced Life Planning
• Advanced Directives
• Assisted Living
• 24 hour care
• Long-term Care
OUTCOMES MANAGEMENT

- What we measure
- How we measure
- Vendor responsibility
- HCAHPS
- Data gathering
- Data analysis

What we measure gets done
PROBLEM SOLVING

- Important first questions
- Type of data to gather
- Compiling data
- Benchmarking
- Reporting
- Performance Improvement
HOW DATA WORKS

- New service line
- Staffing or opening a new unit (OBS)
- Extended coverage weekends and late afternoons
- ED coverage
- Adding a SNF
QUALITY IMPROVEMENT

• Six Sigma
  • Process Improvement
  • Hard Savings
  • Soft Savings

- PDCA Cycle
- Plan, Do, Check, Act
- Fast Acting, Data gathering is succinct
- Most useful in health care
Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process—from manufacturing to transactional and from product to service. (isixsigma.com)

Working towards standardization to elimination of outliers (lean projects)
Defines hard and soft savings
PDCA

• Plan – decision on data gathering, asking the question, creating a plan
• Do – using data to create an action plan and put it in plan
• Check – periodically challenging the plan and checking progression of plan
• Act – if first three steps are controlled and useful, act on the plan and put it in play, communicate and re-start cycle if needed.
Measure

Benefits of improvements (CHECK)

Communicate improvements and reassess (ACT)

Focused Data Collection for Improvement (PLAN)

Implement improvements (DO)

Measure Benefits of Improvements (CHECK)
QUALITY IMPROVEMENT

• Denials process
• New programs
• Staffing justification
• Utilization of services
• Aligning best practices with patient safety measures
• Patient is admitted for a hip replacement and has not been hospitalized in the last 6 months. The last admission was for a syncopal episode. He is hospitalized for 6 days due to some complications and was admitted to an inpatient rehabilitation facility (IRF) for acute and intensive rehabilitation. He is discharged from the IRF after 22 days and is discharged home with family.

• What type of Medicare days has the patient used?
• How many Medicare days has the patient used?
• If readmitted in 30 days, how many days does the patient have remaining?
• Acute days
• SNF days
Patient is admitted to an acute care facility for fever, sepsis and altered mental status. He is hospitalized for 58 days and is discharged to a SNF. The patient is in a SNF for 32 days and is released home with 24 hour care. After 3 days at home, the patient falls and suffers a CVA and is re-admitted for treatment for the condition and spends 8 more days in the acute care setting. The patient then returns to the SNF for rehab and medication management and uses 52 days. The patient does well and goes home again with 24 hour care.

- How many acute days has the patient used?
- How many SNF days has the patient used?
- When does the co-pay begin in the SNF setting?
- When does the co-pay begin in the acute care setting?
The patient is admitted to the acute care setting with a diagnosis of acute renal failure. He is covered under a commercial payer at the time of admission. During this admission, it is determined the patient is end stage renal disease and will require three times a week dialysis.

- Is the patient eligible for Medicare at this time?
- What is the determination for a recipient of dialysis to be eligible for Medicare coverage?
- Once eligible, how long is the patient eligible?
- If patient receives a transplant, how long after the transplant does Medicare cover the patient?
MEDICARE AND YOU


• www.medicare.gov - coverage for pts.
  • Discharge planning guide

• www.medicarecompare.gov
AFTER YOU PASS.....
SUCCESS!!!
YOUR PIN