

2019 Compass for Case Managers

Course	Module Description	Learning Objectives
100-19: Scope of Services, Practice and Education	<p>Case Management History, Regulations and Practice Settings <i>Case management practice has a rich history and continues to evolve as healthcare delivery becomes increasingly regulated and complex. Patients need guidance to traverse these complex regulatory issues, help to receive needed resources as they become increasingly difficult to obtain, and offer support as a result of the psycho-social complexities of diverse, distant or absent families. As healthcare evolves so must the practice of case management.</i></p>	<ul style="list-style-type: none"> • Discuss the mission of case management in the various practice settings. • Explain the history of case management. • Explain the importance of the evolution of case management.
	<p>Regulatory Impact on Case Management, Trends and Practice Settings <i>As legislation and regulations in care delivery move forward, case management responsibilities continue to increase. Case managers are on the precipice of a new and exciting tomorrow. They will be responsible for the continuum of care – prior to admission to the hospital, during the hospital stay, and after issuance of a safe and appropriate discharge plan. Clinic and community case managers continue care to keep patients in their homes and out of the hospital.</i></p>	<ul style="list-style-type: none"> • Identify regulatory issues that influence case management practice. • Explain the importance of The Balanced Budget Act on balancing care quality and cost. • Define patient roles and expectations as outlined in the Patient Self-Determination Act. • Identify healthcare trends in reimbursement.
	<p>Case Management Scope of Services and Education <i>The case management scope of service represents the functions and responsibilities associated with the case management practice. To ensure that case managers provide the most optimal care, education and professional development become key tenets to the practice. In the ever-evolving healthcare field, case managers are expected to understand the need for continual education.</i></p>	<ul style="list-style-type: none"> • Define the scope of practice for case management. • Create awareness of the need for continuing professional development. • Identify professional certifications available to case managers.
	<p>Case Management Standards of Practice <i>Case management standards of practice describe a competent level of care in each phase of the case management process. Case managers must integrate collaboration, accountability, professionalism, and advocacy into their standards. Doing so enhances the standards of practice to ultimately maintain safe and competent care across the continuum.</i></p>	<ul style="list-style-type: none"> • Identify the case management standards of practice. • Define collaboration, accountability, professionalism, and advocacy as they relate to the practice of case management. • Explain the importance of care coordination and resource management.
200-19: The Professional Case Manager	<p>Professionalism <i>Professionalism is more than just a subjective opinion about a person or group. It is the conduct, aims, or qualities that characterize a profession</i></p>	<ul style="list-style-type: none"> • Define and provide an overview of professionalism as it relates to individual case managers.

	<p><i>or professional. A case manager’s professionalism is demonstrated through behaviors, competence, appearance, speech, and communications. The level of individual professionalism directly correlates to the level of credibility and respect they receive from patients, peers, and leadership. A highly credible and respected case manager reflects highly on the organization and practice he or she represents.</i></p>	<ul style="list-style-type: none"> • Describe the attributes of a case management professional. • Describe the tools available to case managers for professional competency.
	<p>Communication <i>Communication involves a variety of methods used to interact with others, and case managers should strive for effective communication regardless of the medium. Case managers should be aware of societal or cultural influences regarding interpersonal communication and adhere to rules of etiquette established for successful communication. Obstacles to effective communication should be identified and overcome quickly and best practices for collaboration should be implemented at all times.</i></p>	<ul style="list-style-type: none"> • Describe communication theory and methods of successful communication. • Identify enhancers and detractors to successful communication. • Define collaboration and recognize the value of collaboration in achieving desired outcomes.
	<p>Professional Tools for the Case Manager <i>Accountability and responsibility should be ingrained in every decision a case manager makes. Case managers must also manage the consequences and impact of their decisions on patients, the care team, and the organization. In addition to being entrusted with a patient’s quality of care, accountability for case managers can take other forms. Keeping abreast of industry, clinical, or legal changes and best practices is a key element – as is a high level of collaboration and communication that must always be maintained with patients, caregivers, and colleagues.</i></p>	<ul style="list-style-type: none"> • Define accountability and responsibility in the profession of case management. • Explain how accountability and responsibility relate to the roles of case managers. • Discuss components of ownership for case managers throughout the continuum of care.
	<p>Professional Tools in Action <i>In order to maintain a high degree of accountability, performance indicators, variance reports, and other metrics are utilized. Case managers are responsible for noting variances in patient care in order to establish an action plan or report on quality of care. Serving as both an advocate to the patient and a member of the care team, the case manager is able to seamlessly integrate patient needs with high quality care. As a result of the case manager’s diligent and appropriate navigation through the care continuum, patient satisfaction is increased, appropriate reimbursement is received, and positive health outcomes are attained.</i></p>	<ul style="list-style-type: none"> • Identify and analyze variances in patient care. • Discuss the importance of applying all elements of accountability and responsibility to the everyday practice of case management. • Explain the importance of pacing the case.
<p>300-19: Ethics</p>	<p>Part 1: Ethical Standards</p>	<ul style="list-style-type: none"> • Demonstrate the relationship between professional ethics and personal values.

	<p><i>The following will review ethical standards associated with case management practice. It should be noted that this learning module does not represent a specific code of ethics for the American Case Management Association, and the content was derived from subject matter experts in the field and from the associated professional bodies that support case management practice, such as the American Nurses Association and National Association of Social Workers.</i></p>	<ul style="list-style-type: none"> • Define ethics associated with case management practice. • Analyze common threats to ethical standards of practice.
	<p>Part 2: Ethical Standards <i>The following will review ethical standards associated with case management practice. It should be noted that this learning module does not represent a specific code of ethics for the American Case Management Association, and the content was derived from subject matter experts in the field and from the associated professional bodies that support case management practice, such as the American Nurses Association and National Association of Social Workers.</i></p>	<ul style="list-style-type: none"> • Examine case manager ethics within the role of advocacy. • Apply ethical standards of practice to specific case examples. • Practice suggestions for remaining ethically fit.
	<p>Organizational Ethics <i>Case managers must understand how their organization addresses patient decisions regarding care, treatment, and services rendered. Each organization should have mechanisms and policies defining how varying scenarios are handled and when escalations to an ethics committee should occur. Knowing when to consult an organization’s ethics committee, when to terminate a non-therapeutic relationship, and being aware of potential practice liabilities is critical to competent and ethical case management.</i></p>	<ul style="list-style-type: none"> • Describe the importance of organizational views of ethics. • Explain the function of the bioethics committee. • Identify when to consult the ethics committee or appropriate escalate an ethically challenging case.
	<p>Threats to Ethical Practice <i>Ethical threats can occur when a case manager is tempted to not follow standard ethical practice. Common drivers include case manager burnout and low department morale. Case managers should be equipped to safeguard against ethical threats with a pre-designed course of action.</i></p>	<ul style="list-style-type: none"> • Identify common threats to ethical practice. • Explain possible solutions for low department morale or ‘compassion fatigue’. • Describe ways to improve work-life balance and safeguard against ethical threats.
	<p>Ethical Standards in Action <i>Ethical dilemmas are part of daily practice for case managers. Case managers are often consulted to resolve problems in the healthcare delivery and payer systems. Understanding the framework for managing ethical dilemmas is critical as case managers must advocate for the patient even when there are no financial, social, or other resources available. It is important for case managers to recognize when to utilize an organization’s ethics committee or other resource to resolve conflicts or challenges with patient care.</i></p>	<ul style="list-style-type: none"> • Explain the importance of financial stewardship to the patient and organization. • Apply the concept of patient self-determination. • Describe why professional competency is an important ethical consideration to case management practice.

400-19: Medical Legal Topics	<p>EMTALA and the Medical Screening Exam (MSE) <i>All hospitals with a dedicated emergency department that participate in Medicare must meet the statutory requirements of EMTALA. EMTALA requires hospitals to provide a medical screening examination and treatment and transfer, if appropriate, to individuals with an emergency medical condition or women who are in labor. The provisions apply to all individuals who present to the hospital for emergency care, not only Medicare beneficiaries. It is important for case managers to understand these regulations, their implications for patients, and the potential liabilities for organizations found in non-compliance.</i></p>	<ul style="list-style-type: none"> • Define EMTALA and associated terminology. • Describe the requirements of a medical screening exam. • Identify the EMTALA requirements of a dedicated emergency department. • Explain EMTALA regulations governing the transfer of patients. • Discuss when EMTALA investigations occur and what is involved.
	<p>Patient Decision Making and Planning <i>The U.S. legal system dictates that individuals possess autonomy and self-determination, which encompass the right to accept or refuse medical treatment. All persons are deemed competent to make reasoned decisions unless demonstrated to be otherwise. When advocating for patient autonomy and self-determination, case managers must understand the standards upon which capacity and competency assessments are made. This includes an understanding of issues related to informed decision making and planning, including advance directives, surrogate decision making, guardianship, and consent.</i></p>	<ul style="list-style-type: none"> • Discuss key factors of self-determination, patient choice, and patient rights. • Describe how determinations of capacity and competency can affect patient autonomy. • Define guardianship and protective custody and explain the involvement of case managers in these cases. • Explain the requirements and best practices for ensuring patient choice.
	<p>Affordable Care Act and Other Medical/Legal Topics <i>The Patient Protection and Affordable Care Act, often referred to as the Affordable Care Act (ACA) was enacted and signed into law in 2010. Since then, the U.S. has implemented law and adapted to the regulatory overhaul and expansion of coverage. Regardless of the debate, the ACA has a significant impact on the way healthcare providers treat and manage patients. Case managers are obligated to examine the impact regulations have on patient care planning and track impending changes to legislation. Because the ACA also impacts all payers in healthcare, patient education is an important component of patient care.</i></p>	<ul style="list-style-type: none"> • Discuss key provisions of the Patient Protection and Affordable Care Act. • Explain how the ACA impacts case management. • Discuss case management’s role in the ACA. • Define the 21st Century Cures Act.
	<p>Two Midnight Rule <i>Hospitals can provide care to patients on either an inpatient or outpatient basis. Reimbursements from Medicare are paid separately based on patient status and represent different payment amounts for patients receiving similar services, along with differing cost-sharing obligations. Shifting of services between inpatient and outpatient has significant implications for Medicare and its beneficiaries. CMS’ “Two Midnight Rule” defines specific requirements for patient assignment and</i></p>	<ul style="list-style-type: none"> • Describe the key tenets of CMS 1599-F. • Discuss the “Two-Midnight Rule” and its implications for case management practice. • Restate the necessary requirements for a 20-day certification statement. • Explain the qualifying nights for a skilled nursing facility transfer. • Define the use of provider liable.

	<i>is intended to add discord around Observation versus Inpatient hospital stays. Case managers must understand the provisions of the rule and its implications to the patient and provider.</i>	
500-19: Medicare and Medicaid	<p>Understanding Medicare Program Oversight <i>Addressing improper payments in the Medicare fee-for-service program is a top priority for CMS. Preventing improper payments actively involves every division of CMS as well as effective coordination with their partners, Medicare and Medicaid contractors, and providers. Understanding the roles and missions of the various contractors and their effect on healthcare practice provides a foundation for case managers as they effectively support the monitoring of patient status errors and appeals.</i></p>	<ul style="list-style-type: none"> • Define the roles of the RA, MAC and other regulatory auditing entities. • Explain the impact that regulatory auditor activity has on healthcare organizations. • Discuss proactive strategies that case management can deploy to minimize risk or prepare for a successful appeal. • Define the five levels of Medicare appeals.
	<p>Medicare Patient Notifications <i>Case managers should be aware of the Medicare Conditions of Participation requirements for patient notification and be familiar with the tools and forms needed for compliance. It is important to understand the triggers requiring an Advance Beneficiary Notice of Non-coverage as well as the Hospital Issued Notice of Non-coverage and Medicare Outpatient Observation Notice. It is additionally important to be familiar with the form and delivery of the Important Message from Medicare outlining a patient’s right to appeal a discharge. Recognition of the requirements, appropriate forms, and timing for issuance can be burdensome for case management departments, but it is necessary to be vigilant, provide staff education, and implement structure to ensure the Conditions of Participation requirements are met.</i></p>	<ul style="list-style-type: none"> • Identify the tools and forms available to comply with Medicare Conditions of Participation. • Describe how and when to utilize various forms for proper patient notification. • Explain the regulatory requirements that govern the ‘Important Message’ from Medicare regarding discharge.
	<p>CMS Programs and Conditions of Participation <i>At an annual cost of \$260B, Medicare is one of the largest health insurance programs in the world. Providing nearly universal health insurance to the elderly as well as many disabled, Medicare accounts for almost 17% of U.S. health expenditures, one-eighth of the federal budget, and 2% of GDP. Medicare has evolved over the past 50 years through its mandates and Conditions of Participation. With a significant percentage of the population covered by Medicare programs, it is imperative that case managers understand the program, its requirements of providers, and its requirements for individual eligibility and coverage.</i></p>	<ul style="list-style-type: none"> • Describe the CMS Conditions of Participation and how they relate to case management. • Describe the Hospital Payment Monitoring Program. • Demonstrate a high-level understanding of Medicare programs, including the eligibility requirements for beneficiaries.
	<p>Medicare, Medicaid and Coverage Options <i>An important part of appraising the implications and related risks for various reimbursement payment models is having a foundational</i></p>	<ul style="list-style-type: none"> • Explain in a high-level overview the provisions of Medicare and Medicaid programs.

	<p><i>knowledge of how CMS programs are structured and how requirements for reporting and reimbursement are applied. Case managers, as financial stewards to their organizations and liaisons to the interdisciplinary care teams and patients, must understand CMS' programs to appropriately serve their patient populations and assure appropriate reimbursement of services.</i></p>	<ul style="list-style-type: none"> • Describe coverage and eligibility for Medicare Parts A, B, C and D. • Describe Medicaid coverage and eligibility. • Examine the qualifications of a Federally Qualified Health Center.
<p>600-19: Care Coordination</p>	<p>Overview of Care Coordination and Social Determinants <i>Case management is expected to have a defined method for screening/identification and assessment of patients in need of case management services. Case management must also have defined standards for ongoing monitoring and interventions that advance the progression of care and must include the clinical, psychosocial, financial and operational aspects of care. Patient-centered service is at the core of care coordination and effective case management.</i></p>	<ul style="list-style-type: none"> • Define aspects of care coordination related to case management. • Evaluate the case managers' role in evaluating and managing social determinants. • Discuss the five main social determinants of health and analyze the primary contributors.
	<p>Care Coordination Across the Continuum <i>Care coordination begins before the patient ever presents to the hospital and is a strategic plan for transitions of patients within the healthcare system. It is the summation of the daily activity for case managers. In the bigger picture, care coordination brings all the aspects of patient care into an orderly focus. It brings all resources, both medical and human, to the table to produce an optimal outcome for the patient. Case managers must understand the activities involved in effective care coordination and deploy effective patient-centered communication to streamline patient care across the continuum.</i></p>	<ul style="list-style-type: none"> • Describe activities of care coordination across the continuum. • Discuss key factors of communication and documentation applicable and necessary for effective and appropriate coordinated care. • Explain the importance of an early discharge plan to avoid delays in care.
	<p>Discharge Planning <i>Discharge planning in the care coordination process guides acute care patients efficiently through the continuum of care to optimal health outcomes. A patient's journey through an acute care organization to discharge and the next level of care or to home is rarely straightforward. Each patient's care needs are coupled with unique circumstances, resources and individual issues. Through experience, careful preparation, and the education and involvement of all stakeholders, case managers can implement processes to identify and navigate key barriers.</i></p>	<ul style="list-style-type: none"> • Describe the key components of the discharge planning process. • Discuss the rules and regulations pertaining to discharge planning activities. • Discuss the patient management and informational gathering strategies and best practices.
	<p>Understanding and Preventing Readmissions <i>Effective management of transitions in the care continuum is an important driver for ensuring quality clinical outcomes. Missteps in appropriate transitions can quickly turn a standard case into a complex case and can often result in costly and disruptive hospital readmissions</i></p>	<ul style="list-style-type: none"> • Explain the negative impact of readmissions on the patient and healthcare organization. • Discuss the CMS regulations concerning reimbursement for readmissions.

	<p><i>for the patient. Many payer reimbursement models recognize the significant negative impact of readmissions and financially incentivize or penalize organizations to encourage better management of such occurrences. For these reasons, it is important for case managers to apply best practice for effective care, discharge, and transition to prevent avoidable readmissions.</i></p>	<ul style="list-style-type: none"> • Compare root cause analysis methods of preventing readmissions and apply the patient centered planning approach. • Identify key strategies, tools, systems and interventions for preventing readmissions.
700-19: Patient Classifications	<p>Patient Status and Level of Care <i>Patients undergoing treatment at a hospital tend to be classified in a variety of ways based on how they were admitted or the type of services they need. Patient classification should be determined using best practice guidelines and federal rules. Understanding the clinical criteria for classification is key to managing patient cost, hospital reimbursement and quality care.</i></p>	<ul style="list-style-type: none"> • Define patient status. • Differentiate between patient status and levels of care. • Describe the application of clinical criteria in determining patient status and level of care.
	<p>Outpatient with Observation Services <i>Observation services are hospital outpatient services that a physician orders to allow for testing and medical evaluation of a patient's condition. While under observation care. Although a patient's room may be located anywhere in the hospital, the quality of care is the same regardless if the patient is an observation patient or inpatient admission. Patient status affects patient cost, payer reimbursement, and coverage for post-acute facility stays. It is critical for case management staff to understand appropriate assignment, the patient management involved, as well as implications for reimbursement.</i></p>	<ul style="list-style-type: none"> • Define and describe requirements for managing patients receiving observation services. • Describe implications of the Balanced Budget Act of 1997 on the use of observation services. • Define the rules applied to observation services associated with reimbursement.
	<p>Inpatient Admission and Observation Services in Action <i>Patients classifications are largely determined using federal guidelines and best practices as a mechanism for quality care delivery and financial stewardship. Being able to apply these guidelines to real-world scenarios helps case managers better manage patient expenses, hospital reimbursement and overall quality of care.</i></p>	<ul style="list-style-type: none"> • Analyze patient presentation, setting and needs. • Classify patients as best suited for inpatient admission or outpatient with observation services. • Recognize the common triggers that determine appropriate patient assignment.
800-19: Transition Management	<p>Transition Planning <i>Transition management is critical at every stage in the care continuum as patients are guided to optimal health outcomes. A patient's journey through an acute care organization and then discharge to the next level of care or to home, however, is rarely straightforward. Each patient's care needs are coupled with unique circumstances, resources and individual issues. Through experience, careful preparation, and the education and involvement of all stakeholders, case managers can implement processes to identify and navigate key barriers.</i></p>	<ul style="list-style-type: none"> • Describe the key components of the transition management – from patient presentation to discharge. • Identify transition management coverage and legal rights for undocumented immigrants. • Discuss post-acute levels of care and triggers for transitions. • Discuss the elements of cost-benefit analysis.

	<p>Home Health and Outpatient Care <i>Home care and outpatient care services vary widely based on the patient’s needs and are used when a patient is clinically stable and has adequate support. Medicare patients must be certified by a face-to-face encounter in order to receive these home care or outpatient services, such as end-stage renal disease management. Case managers must be aware of the qualifications and coverage stipulations for these types of services.</i></p>	<ul style="list-style-type: none"> • Discuss how and why patients may receive care as an outpatient. • Explain the need for a face-to-face evaluation for home care certification • Cite the Medicare qualifications for renal care.
	<p>Post-Acute Facilities <i>Case managers are the primary link between the patient, the acute care team, and post-acute care organizations. The more knowledge a case manager has regarding the utilization of post-acute care settings – including the appropriate processes, documentation, and approvals for transitioning patients to the appropriate level of care – the more he or she will be able to reduce readmission rates.</i></p>	<ul style="list-style-type: none"> • List the levels of post-acute care facilities and services. • Describe the appropriate post-acute level for patient needs. • Identify the rules and regulations of admission to nursing homes and skilled nursing facilities. • Discuss insurance and CMS coverage for post-acute care.
	<p>Private and Ambulance Transportation Options <i>Proper transportation arrangements must be secured when transitioning a patient, with special consideration given to the medical and financial needs of the patient. Case managers should be aware of specific criteria surrounding clinical indications for varied transportation use. Medicare and other payers establish requirements and restrictions that should be considered by case management when selecting the most appropriate transportation.</i></p>	<ul style="list-style-type: none"> • Cite clinical indications for non-medical modes of transportation for post-acute care. • Describe rules and regulations pertaining to non-medical modes of transportation for post-acute care. • Cite clinical indications for ambulance transportation. • Describe rules, regulations, and payer coverage and limitations for ambulance transport.
<p>900-19: Utilization Management</p>	<p>Utilization Management Overview <i>Utilization management entails evaluation of medically appropriate and efficient use of healthcare services, procedures, and facilities according to established criteria, clinical guidelines or provisions of applicable health benefit plans. Proactive processes can be the best tools, including knowing what key elements and metrics to assess, who to involve and when, and what qualifies as appropriate documentation. It is essential for case managers to understand their role in the utilization management process and the diverse stakeholders, including payers, physicians, physician advisors, business units, and regulatory bodies.</i></p>	<ul style="list-style-type: none"> • Identify the key components of utilization management activities. • Recognize best practices for assessing accurate bedding orders and level of care placement. • Identify DME ordering requirements as defined by the Affordable Care Act.
	<p>Metrics, Complex Cases, and Denial Prevention <i>Case managers work closely with physician advisors as liaisons who support case management with compliance issues, medical necessity,</i></p>	<ul style="list-style-type: none"> • Identify reasons and processes for escalation of patient issues and challenges.

	<p><i>and correct utilization of resources. Case managers should understand how they can proactively prevent medical necessity denials in coordination with physician advisors and how they can assist with cost containment, avoidable days, and medical necessity of one-day stays.</i></p>	<ul style="list-style-type: none"> • Define roles and responsibilities of physician advisors. • Review denial and appeal processes. • Define the case manager’s responsibilities in management of length of stay and collection of metrics.
	<p>Overview of Clinical Documentation <i>Clinical documentation is the primary communication venue to share information about a patient. Although the following discussion will focus on the documentation that occurs in the hospital setting, particularly with the admitted inpatient, some of the lessons carry over to other settings. Though the clinical documentation process involves multiple key players and departments, the case manager maintains an important role in the accuracy and improvement of clinical documentation to ensure effective patient care and seamless communication to healthcare payers.</i></p>	<ul style="list-style-type: none"> • Explain the purpose and goals of having accurate and detailed clinical documentation and the key stakeholders who use the documentation. • Identify historical misrepresentations of clinical documentation and provide a rationale for the importance of clinical documentation improvement efforts. • Recognize the consequences of improper or poor clinical documentation.
<p>1000-19: Resource Management</p>	<p>Overview of Resource Management <i>Resource management involves the coordination, allocation, and delivery of a finite set of tools, time, supplies, workers, and services. It is critical that resources are appropriately managed and adequately delivered. It is also critical for case managers to understand the patient’s income and benefits streams so that decisions can be made for the patient without undue financial hardship. The case manager’s objectives are two-fold: to assure costs are managed for both the patient and organization and to simultaneously serve as the patient’s advocate for an optimal health outcome.</i></p>	<ul style="list-style-type: none"> • Define case manager’s financial stewardship role in managing resources. • Outline key influencers on resource management. • Identify the measures of cost of care, cost reduction interventions, and common high-cost outliers.
	<p>Federal Resources <i>Various resources exist through governmental funding for eligible individuals. Several of these resources have restrictions regarding citizenship, age, disability, income, or medical condition. Case managers should be aware of each program’s eligibility requirements, and any changes to such.</i></p>	<ul style="list-style-type: none"> • Identify assistance programs for low-income individuals. • Describe the importance of Emergency Medicaid and Medicaid Waiver Programs. • Define Railroad Retirement, Social Security and disability benefits, including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).
	<p>Workers’ Compensation and Veteran’s Health Administration <i>When an individual receives Workers’ Compensation – a state mandated insurance for employees that have suffered injuries or illness as a result of their job — case managers must aid in coordinating care with adjusters related to the benefits they receive. Case managers should</i></p>	<ul style="list-style-type: none"> • Describe COBRA insurance coverage. • Outline worker’s compensation coverage and the role a healthcare delivery case manager plays when working with adjusters.

	<p><i>additionally be aware of eligibility specifications for veteran healthcare benefits and enhanced services through the Veteran's Health Administration.</i></p>	<ul style="list-style-type: none"> • Describe veteran's insurance coverage and benefits through the Veterans Health Administration. • Discuss the Dignified Wounded Warriors Care Act of 2007 and aspects of the Veteran's Millennium Health Benefits Act.
	<p>Community Resources and High Needs Populations <i>It is important for case managers to be aware of the resources offered in their community and for the high needs populations they serve. Certain populations benefit from many different supports offered through governmental and charity programs yet are particularly vulnerable as they face barriers to accessing these services. By being aware of the resources available, case managers can bridge the gap by connecting high needs populations with appropriate community resources.</i></p>	<ul style="list-style-type: none"> • Identify benefits of Indian Health Services. • Find resources for patients who have been victims of crime. • Discuss how charities are designed to help patients in need. • Identify optional healthcare alternatives in the community. • Describe the role of rural clinics in patient care.
<p>1100-19: Reimbursement and Patient Coverage</p>	<p>Part 1: Diagnostic Related Groups <i>DRGs are a patient classification system used to identify resources expended for hospital services without considering the therapeutic approaches employed. In the DRG system, patient records are categorized into homogeneous groups according to diagnosis and healthcare expenses involved. Medicare and most payers focus explicitly on documentation to accurately reflect each patient's severity of illness, complexity, and quality of care provided to justify the length of stay or service duration. As care costs are reimbursed based on the accuracy and specificity of such documentation and coding, it is important for case managers to understand the system.</i></p>	<ul style="list-style-type: none"> • Define DRGs and describe how they are used in healthcare. • Discuss how Complications or Comorbidity (CC) and Major Complications or Comorbidity (MCC) can affect the DRG. • Describe relative and blended rates and how they impact reimbursement.
	<p>Part 2: Diagnostic Related Groups <i>DRGs are a patient classification system used to identify resources expended for hospital services without considering the therapeutic approaches employed. In the DRG system, patient records are categorized into homogeneous groups according to diagnosis and healthcare expenses involved. Medicare and most payers focus explicitly on documentation to accurately reflect each patient's severity of illness, complexity, and quality of care provided to justify the length of stay or service duration. As care costs are reimbursed based on the accuracy and specificity of such documentation and coding, it is important for case managers to understand the system.</i></p>	<ul style="list-style-type: none"> • Define All Patient Refined (APR) and Transfer DRGs and how they impact organizations. • Discuss the variables that affect the case mix index. • Examine key strategies for managing DRGs and length of stay.
	<p>Introduction to ACOs and Case Management's Role</p>	<ul style="list-style-type: none"> • Define Accountable Care Organization and identify the key stakeholders.

	<p><i>Accountable Care Organizations (ACOs) restructure how healthcare delivery and reimbursement has been historically handled. The primary mission of an ACO is to ensure that providers are maintaining a patient-centered approach to planning care through the continuum while increasing access and quality care for patients. It is important for case managers to understand an ACO's function and how case management functions within its structure.</i></p>	<ul style="list-style-type: none"> • Review the purpose and desired outcomes of ACOs. • Explore the implications of ACOs for case management and the case management function within an ACO.
	<p>ACO Models, Quality Measures and Bundled Payments <i>The Center for Medicare and Medicaid Services, institutes measures intended to assure that the quality of patient care rises while costs are kept down. The ACO model is structured toward these outcomes. Case managers should be knowledgeable about ACOs, their plans of care, and reimbursement policies.</i></p>	<ul style="list-style-type: none"> • Compare and contrast the different ACO models. • Identify the purpose and variable models for bundled payments. • Review the steps that a case manager can perform to improve quality measures.
<p>1200-19: Human Trafficking for Case Managers</p>	<p>What is Human Trafficking? <i>Human trafficking is multi-billion-dollar global criminal issue, which enslaves close to 25 million men, women, and children around the world. Human trafficking does not just occur in faraway countries, it is happening all over the United States as well. For this reason, healthcare professionals, especially case managers, need to be aware of the signs, be able to identify victims, and be capable of providing the best care and resources possible. This training will provide an overview of human trafficking, including the definition and types of trafficking that occur, the global and national coordinated efforts to stem and halt the growth of the industry, the legal ramifications for those involved, and the types and background of victims.</i></p>	<ul style="list-style-type: none"> • Define human trafficking and the types of trafficking in persons. • Describe the three trade partners in human trafficking- the trafficker, consumer, and victim. • Identify laws that relate to human trafficking.
	<p>Human Trafficking in the Healthcare Setting <i>Human trafficking is a major public health problem, both domestically and internationally. Healthcare providers are often the only professionals to interact with trafficking victims who are still in captivity. Healthcare services are also the most accessed service by human trafficking victims. Although these patients often present in the healthcare delivery setting with 'red flag' indicators, often the victims are rarely identified. When case managers are knowledgeable of the signs, and aware of the implications, they are better prepared to quickly and appropriately identify victims and provide the assistance, care and resources they need.</i></p>	<ul style="list-style-type: none"> • Explain health issues commonly identified in human trafficking victims. • Identify potential high-risk patients through the use of 'red flag' indicators. • Explain the neurology of trauma and how it affects the victims of human trafficking.
	<p>Healthcare Protocols <i>As a patient advocate, it is important for case managers to consider the impact a defined Human Trafficking protocol could have on their</i></p>	<ul style="list-style-type: none"> • Explain factors affecting the decision to screen, considerations during screening, and provider

	<p><i>organization and the patient's they serve. Clear guidelines as to how to approach, identify, and manage potential labor and sex trafficking victims and traffickers is key to optimal outcomes. This module will review different aspects of a victim-centered, trauma-informed approach to Human Trafficking protocol.</i></p>	<p>and patient barriers that may affect disclosure when dealing with human trafficking victims.</p> <ul style="list-style-type: none"> • Identify considerations for conducting the physical exam and for documentation. • Identify the needs a trafficked patient may have after the visit, including medical care, referrals, risk assessment, and safety planning. • Describe the principles of victim-centered and trauma-informed care.
<p>1300-19: Leadership/Advanced Practice</p>	<p>Essential Case Management Department Operations <i>Case management represents a wide range of services with multiple delivery methods in hospitals and health care delivery systems. As case management needs vary, so do the effective models for each organization. This module will explore several case management models which leaders in the field should be aware of and accountability measures for which these models can be assessed.</i></p>	<ul style="list-style-type: none"> • Describe the various practice models of case management. • Compare the differences of each practice model and how they relate to each other. • Apply accountability measures towards the assessment of case management practice models.
	<p>Quadruple Aim <i>The Triple Aim was first developed by Dr. Don Berwick and the Institute for Healthcare Improvement in 2007 as a benchmark and philosophy of how to deliver care and contain cost. The Triple Aim has since been widely accepted as a compass to optimize health outcomes and system performance. In order to achieve the three tenets of the Triple Aim, the issue of burnout must be addressed to implement it successfully. The Quadruple Aim includes the addition of Care Team Well Being; it is the balancing act between provider and patient satisfaction. It is important for leaders and advanced practitioners to understand these frameworks and appropriately educate their staff on best practice models.</i></p>	<ul style="list-style-type: none"> • Define the main tenets of the Triple Aim framework. • Explain the importance of care team well-being in the context of the Quadruple Aim. • Describe health equity and its importance in population health.
	<p>Professional Development and Mentorship <i>In order to improve care team well-being and promote quality care, professional development and mentorship can be a tool to transform staff members and improve overall staff outlook. Mentorship can come in various forms and can be intentional or inadvertent, but the relationship for the mentee and mentor can be beneficial for all parties. The review process is also an opportunity for peers, managers and employees to provide professional feedback to individuals.</i></p>	<ul style="list-style-type: none"> • Analyze several common leadership styles and the context in which each would be most appropriate. • Summarize key elements to developing emotional intelligence as a leader. • Discuss actions case managers may take in order to develop into a leader and mentor. • Describe the process and advantages for conducting 360° reviews.
	<p>Leading a Highly Engaged Team</p>	<ul style="list-style-type: none"> • Describe what is meant by employee engagement.

	<p><i>Improving patient care is a priority for all healthcare institutions and it is critical for leaders and advanced practitioners to engage their staff. Research has shown direct correlations between employee engagement and patient satisfaction, healthcare outcomes, and even revenue. This training will discuss research-based employee engagement strategies that can be employed in any organization.</i></p>	<ul style="list-style-type: none"> • Identify the benefits of employee engagement to healthcare organizations. • Discuss key strategies for increasing employee engagement.
<p>1400-19: Effective Pediatric Case Management</p>	<p>Pediatric Care Coordination <i>Children bring a unique perspective to case management due to their personalities, developmental levels, family dynamics, complicated financial situations, as well as psycho/social and transition of care needs. Although care coordination processes are largely the same as other populations, there are unique considerations when dealing with pediatric patients. It is important for pediatric case managers to be aware of the unique aspects as they deliver age-appropriate services.</i></p>	<ul style="list-style-type: none"> • Discuss the elements, benefits, and outcomes of the Family-Centered Care model and family conferences. • Recognize the importance of multi-disciplinary team members in identifying the child’s needs and family’s concerns. • Explain developmental phases and how they relate to coordinating care.
	<p>Utilization and Resource Management for Pediatric Care <i>Utilization management includes evaluating medical appropriateness and efficiency of healthcare services, procedures and facilitates according to established criteria, clinical guidelines or provisions of applicable health benefits. Pediatric case managers guide families through the complexities of health benefits by working with payers, providers, and regulatory bodies and utilizing resources for under- or uninsured patients. To maximize efficiency, pediatric case management programs should be evaluated based on key performance indicators.</i></p>	<ul style="list-style-type: none"> • Explain why screening criteria is utilized to ensure pediatric patients receive appropriate care at the correct level of care. • Discuss different coverage options and resources for low-income families. • Evaluate pediatric case management programs for effectiveness and process improvement.
	<p>Pediatric Transitions of Care <i>Pediatric patients can be complex due to psycho-social issues, chronic diseases, family dynamics, and many other factors that play a role in the discharge plan. It is important to assess the patient needs, identify the family unit, and assess possible barriers to the transition plan or discharge plan. It is critical for the pediatric case manager to work closely with the family or caregiver to engage them in child’s care and receive buy-in when identifying post-acute services for children with recurring or complex needs or conditions.</i></p>	<ul style="list-style-type: none"> • Discuss the components of a discharge plan and key aspects to take into consideration for pediatric patients. • Evaluate and describe varying pediatric transitional care options. • Explain the importance and best practices for identifying a follow-up physician for a successful discharge plan.
	<p>Child Abuse and Neglect <i>Out of all case management responsibilities, the role of the patient advocate is one of the most important and most challenging, especially for the pediatric population. Patient advocacy should always be in mind as it applies to all roles and functions that a case manager performs. One of the key areas of advocacy for pediatric patients relates to child abuse</i></p>	<ul style="list-style-type: none"> • Describe the key tenets of advocacy for the pediatric patient. • Identify the different types of child abuse, including the physical and emotional characteristics and each, and learn how to identify potential victims and abusers.

	<p>– physical, sexual, emotional and neglect. Case managers should be aware of the signs and understand how to appropriately handle every situation to address issues and achieve desirable outcomes.</p>	<ul style="list-style-type: none"> • Explain the proper techniques for the evaluation or assessment of a child suspected of having been abused or neglected along with the related HIPAA requirements.
	<p>Other Pediatric Psychosocial Aspects of Care <i>Case management focus on the prevention, early detection, and management of psychosocial problems pertinent to optimal child and family health and development is increasingly important. Children present unique psycho/social issues and are highly impressionable as they develop sense of self and awareness. Case managers should be aware of the signs of child trafficking, suicidal tendencies, substance abuse, and other adversities to appropriate coordinate effective care.</i></p>	<ul style="list-style-type: none"> • Recognize the important role that a provider has with child trafficking victims. • Discuss risk factors and evaluation strategies for suicidal patients. • Explain how drug abuse affects the pediatric population and identify risk and protective factors. • Discuss key factors of pediatric self-determination, cultural competence, and social needs.
<p>1500-19: Heath Plan Case Management</p>	<p>Defining the Health Plan and Its Role in Case Management <i>Case management plays a vital role within health plans. Case managers act as catalysts to help members navigate through complex health systems by establishing cohesion amongst a member’s established care team, enabling members to achieve their personal health goals most effectively and efficiently, thereby lowering costs. This training outlines health plans and how case management functions within their structure.</i></p>	<ul style="list-style-type: none"> • Describe the structure of health plans and how case management is incorporated within the organization. • Explain case management responsibilities and goals as well as how to implement and monitor patients and patient populations. • Apply case management standards and practice to health plan case management.
	<p>Introduction to Health Plan Case Management <i>Health plans use risk analysis and stratification to better coordinate care for populations. As value-based care becomes the primary focus of healthcare organizations, providers now need to broach population health management and to manage risk stratification with a delicate balance. It is important for case managers to focus on patients’ individual and distinct health signs to enhance quality outcomes.</i></p>	<ul style="list-style-type: none"> • Explain the importance of risk analysis and stratification to the health plan. • Define the risk categories as they relate to different patient populations. • Identify the most expensive complex diseases and the challenges in providing coverage for affected patients.
	<p>Essential Responsibilities of the Health Plan Case Manager <i>Health plan case managers should be aware of the standard essential responsibilities that lead to optimal patient care. It is important to tailor patient interventions based on population and risk group. Population groups will also dictate the metrics on which success is measured and effectiveness of the interventions.</i></p>	<ul style="list-style-type: none"> • Discuss the coordinated care approached for different risk groups. • Define general health plan case management staffing ratios and the productivity measures used to rate success. • Explain the essential responsibilities of the health plan case manager.