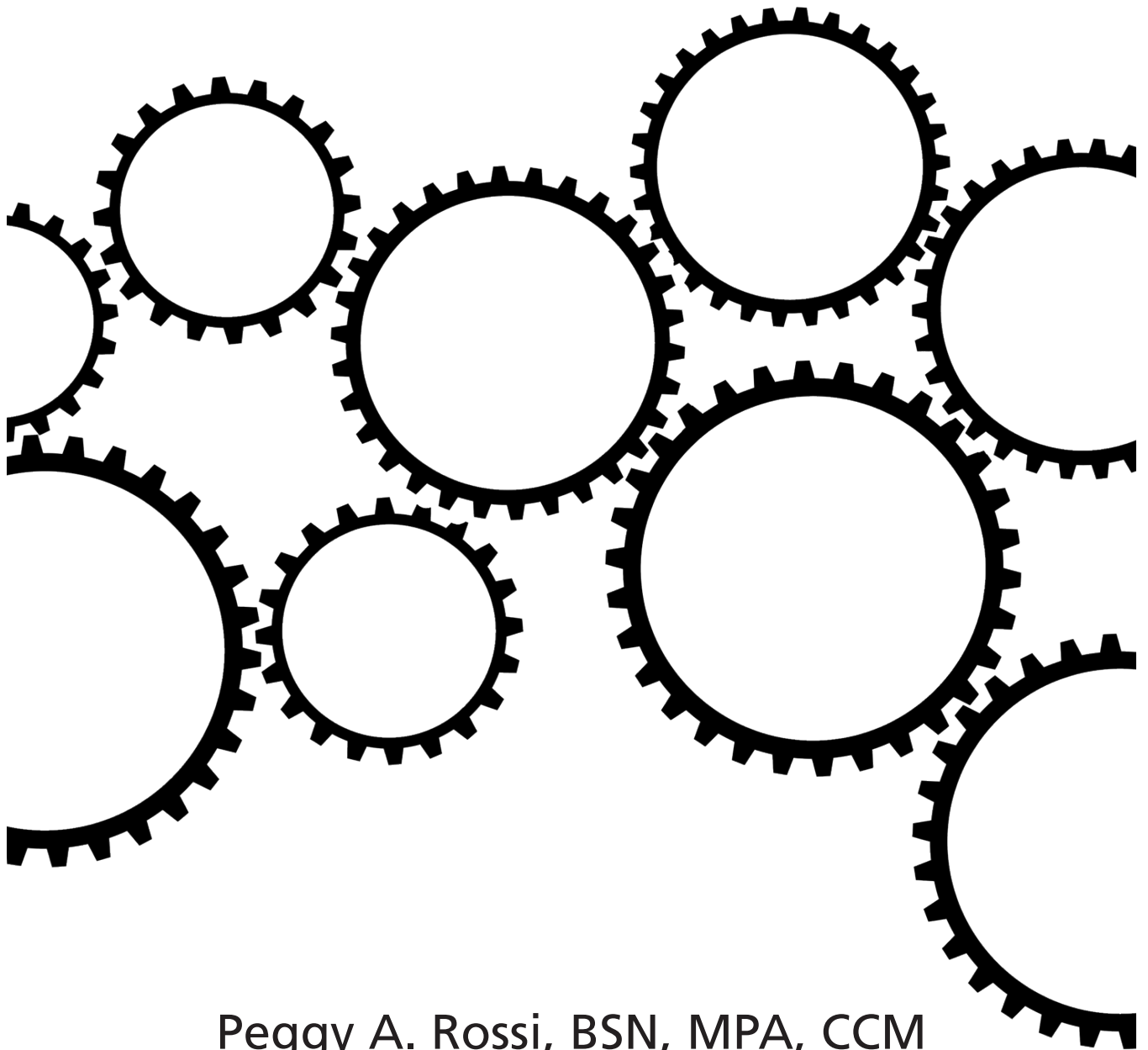


THE HOSPITAL CASE MANAGEMENT ORIENTATION MANUAL



Peggy A. Rossi, BSN, MPA, CCM
Reviewed by Karen Zander RN, MS, CMAC, FAAN

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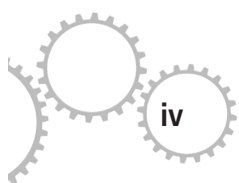
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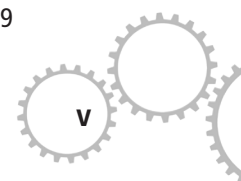
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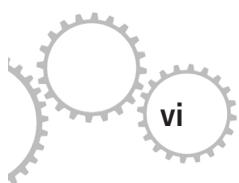


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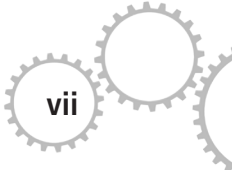


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About the Author

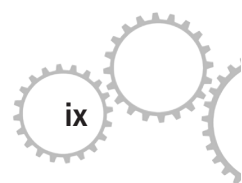
Peggy A. Rossi, BSN, MPA, CCM

Peggy A. Rossi has more than 50 years of nursing experience, including case management, utilization review, and utilization management.

Rossi is currently a consultant at The Center for Case Management in Wellesley, Mass., where she provides hospital case management consulting services to ensure clients' compliance with state and federal law and to ensure accurate reimbursement. As a consultant, she addresses hospital case management staff needs, such as education and orientation, competency testing, utilization management, readmission prevention, daily care coordination round and long-stay round refinement, policy and procedure development, denial and appeal management, and process evaluation.

Her previous experience includes positions such as director of clinical services, director of medical management, director of utilization review and case management, senior discharge planner, and marketing director in various provider and third-party payer settings.

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About the Reviewer

Karen Zander, RN, MS, CMAC, FAAN

Karen Zander, president and CEO of The Center for Case Management in Wellesley, Mass., has more than 40 years of healthcare experience. In this role, she serves as a consultant and educator to hospitals, physicians, healthcare systems, and software, pharmaceutical, and consulting companies worldwide for the development of tools, roles, and systems to support provider-side control of cost and quality.

Zander previously was associated with New England Medical Center Hospitals (now Tufts Medical Center), where she served in multiple roles, including organizational development specialist in the nursing department, director of consultation in the Center for Nursing Case Management, inpatient/day hospital psychiatric service nurse leader, and staff education instructor.

Certified as a clinical specialist in adult psychiatric and mental health nursing by the American Nurses' Association, Zander maintained a private psychotherapy practice specializing in the treatment of combined medical and psychiatric conditions for 25 years.

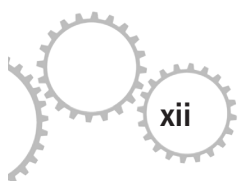
Zander's faculty and preceptor appointments include Northeastern University (present), Massachusetts College of Pharmacy & Health Sciences University, Boston University School of Nursing, University of Lowell, University of Connecticut, Adelphi University, and Tufts University School of Medicine.

About the Reviewer

Zander has written numerous books and articles on case management, including *Mission-Critical Practices for Safe, Smooth, and Sustained Discharges*, *Competency Evaluation Tools for Case Management Professionals*, *Hospital Case Management Models: Evidence Connecting the Boardroom with the Bedside*, and *Primary Nursing: Development and Management*. Books written with coauthors include *Emergency Department Case Management: Strategies for Creating and Sustaining a Successful Program* and *Handbook of Professional Practice*. She contributed chapters to *Case Management in Theorie und Praxis*, *Reengineering Nursing and Health Care Delivery: The Next Generation*, *The Nurse Manager's Problem Solver*, *Current Issues in Nursing* (third and fourth editions), *Managing Nursing Care: Promise and Pitfalls*, *The Delivery of Quality Health Care*, *Pioneers in Healthcare Quality*, *Patient Care Delivery Models*, and *Peer Consultation in the Group Context*.

Articles written by Zander have appeared in "Care Management," "Professional Case Management," "Journal of Integrated Care Pathways," "Nursing Administration Quarterly," "The Remington Report," "The Case Manager," "Critical Care Nursing Clinics of North America," "Clinical Performance and Quality Healthcare," "Seminars for Case Managers," "International Nursing Review," "Nursing Management," "Caring Magazine," "Dimensions of Critical Care Nursing," "Frontiers in Health Service Management," "Health Care Supervisor," and "Nursing Life."

Visit The Center for Case Management at www.cfm.com/wordpress1. Contact Zander at kzander@cfm.com.





Foreword

Welcome to the wonderful field of case management. I hope as you begin your new role and gain increasing competence, you will agree that case management is both challenging and rewarding every day. Trust me, it will demand that you integrate your previous experiences as a healthcare professional with the new information that is included in this valuable resource.

As a case manager, you must create a team of professionals who pay attention to each of your patients' and families' needs, coordinate care between admission and discharge, negotiate reimbursement, facilitate key decisions, and help them navigate their acute care admissions and transitions to the level of care necessary to help them recover, manage their chronic condition(s), and sometimes experience a comfortable death. Case management positions demand that you rely on everything you already know about people and healthcare. *The Hospital Case Management Orientation Manual* is an invaluable resource that will start you on the path to case management competence and beyond.

Be good to yourself and to those with whom you work. Be patient with yourself and others, especially during orientation, because the knowledge base in case management becomes more complex by the day, as this book illustrates throughout. Always remember as you perform your case management responsibilities (e.g., care coordination, discharge planning, utilization management reviews, psychosocial interventions, referrals to community resources) to strive to act and plan in a manner that reflects how you would want things done for yourself or a loved one.

Foreword

The good news is that if you have been a great clinician and team player as a nurse or social worker, you will undoubtedly become a great case management professional.

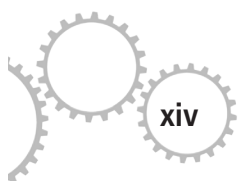
Best wishes,

Karen Zander, RN, MS, CMAC, FAAN

President and CEO

The Center for Case Management, Inc.

Wellesley, Mass.



Chapter 1

Case Management Basics

Definitions

Case management (CM) has more than one definition.

The Case Management Society of America (CMSA) defines it as follows. “Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.”¹

Nursing CM is a dynamic and systematic collaborative approach to provide and coordinate healthcare services to a defined population. The framework includes five components: assessment, planning, implementation, evaluation, and interaction.

Nurse case managers actively participate with their clients to identify and facilitate options and services for meeting individuals’ health needs, with the goal of decreasing fragmentation and duplication of care and enhancing quality, cost-effective clinical outcomes.²

The American Case Management Association (ACMA) defines it yet another way. “Case Management in hospitals and healthcare systems is a collaborative practice model including

1 Case Management Society of America definition of Case Management: www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx.

2 U.S. National Library of Medicine National Institutes of Health and mapping the literature of case management: www.ncbi.nlm.nih.gov/pmc/articles/PMC1463029.

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patients, nurses, social workers [SW], physicians, other practitioners, caregivers and the community. The case management process encompasses communication and facilitates the 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 rights to self-determination.”³

Healthcare is changing and case managers feel the impact, as their responsibilities reflect these changes. However, a case manager's core role remains serving as the driver of patient-centered care. This generally involves one or both of the following:

- ❖ Serving as care coordinator for the development, implementation, and linkage of resources to meet the current and future anticipated needs (e.g., medical, psychosocial, socioeconomic) of patients and their families as they move through the continuum of care
- ❖ Serving in utilization management to collaborate with physicians and others to ensure that patients are at the right level of care to ensure correct reimbursement and minimize payment denials

Serving as the driver means ensuring that the multidisciplinary team, including physicians, works together to eliminate barriers to care and timely discharge.

One size does not fit all in CM. Plans are individualized, so case managers must remain flexible and learn to think outside the box. This is even more critical as roles change and hospitals strive to meet demands for quality outcomes and to remain competitive in the marketplace. Consequently, case managers can expect their role and authority to extend beyond the hospital walls into the community. Skills require continuous updating.

As a rule, SWs and RNs are the foundation of patient CM as it pertains to care coordination or discharge or transition planning, linkage to resources, crisis intervention, and utilization review. Each of the roles brings to the table a unique blend of skills and knowledge. When working side by side as a team, they synergistically maximize the use of skills, knowledge and talents of both disciplines.

³ American Case Management Association definition of case management: www.acmaweb.org/section.aspx?sID=4&mn=mn1&sn=sn1&wpg=mh.

Goals of an Effective Case Manager

Hospitals generally consider staff members who perform care coordination, discharge planning, or utilization management case managers. This term can be confusing, because it does not always reflect the role accurately. Regardless of the title and setting, CM goals are the same. They are:

- ❖ Provide high-quality and cost-effective clinical outcomes of care by using efficient and timely linkage to care resources across the continuum
- ❖ Contain or reduce costs by balancing the utilization of resources necessary to achieve realistic clinical outcomes and prevent readmissions
- ❖ Ensure that patients are at the right levels of care at all times and that lengths of stay are as efficient and brief as possible
- ❖ Ensure a satisfactory CM experience for everyone

Core Competencies

Patients, their families, and healthcare professionals assume that case managers and physicians who provide CM services are competent. Remember to follow the hospital's policies and procedures and act within the realm of the job description for the role as well as any standards outlined by a state's Practice Act (e.g., nurse or SW), which can be located on the state's licensing board website.

A competent case manager does the following:

- ❖ Relies on accurate assessments for interventions
- ❖ Develops plans that include recommendations from multidisciplinary care teams
- ❖ Establishes specific goals

The CM process for nurses is the nursing process or scientific method taught in nursing school—assessment, goal planning with interventions, implementing, and evaluating results.

The sum total of the knowledge and values that case managers bring to the job reflects their competency. Competent performance requires knowledge, skill, and energy that arise from an honest belief in the work. Book knowledge is important, but so is practical application of that knowledge.

Chapter 1

CMSA's five core competencies include the following:

- ❖ The ability to assess physical and psychological factors impacting the case
- ❖ The ability to coordinate service delivery
- ❖ The ability to understand the benefit provisions of an insurer, the various types of payers, as well as the public funding programs to which a patient might be entitled
- ❖ Knowledge of nursing practice concepts
- ❖ Knowledge of community resources, levels of care, as well as the standards for care within the community resources⁴

CMSA's six core components of CM include knowledge of the following:

- ❖ Psychosocial aspects that impact the patients and their care or perception of the illness or injury
- ❖ Healthcare reimbursement
- ❖ Rehabilitation
- ❖ Healthcare management and delivery
- ❖ Principles of practice
- ❖ CM concepts⁵

Additional knowledge and skill competencies are:

- ❖ Education
- ❖ Experience and expertise in the practice setting, including political savvy
- ❖ Ability to see patient and family as a whole
- ❖ Knowledge of protocols, resources, services, funding programs, and patient entitlements
- ❖ Communication skills, oral, written, and listening
- ❖ Problem-solving abilities and use of critical-thinking skills
- ❖ Creative abilities, energy, and flexibility
- ❖ Cultural and linguistic sensitivity
- ❖ Age-specific competencies
- ❖ Awareness of potential literacy issues
- ❖ Time management

4 Case Management Society of America and Standards of Practice for Case Management: www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf.

5 Ibid.

- ❖ Ability to be self-directed
- ❖ Confidence in and respect for one's self and one's colleagues⁶

Other important skills used by successful case managers include the following:

- ❖ Clinical knowledge (pathophysiology, anatomy, pharmacology, and general courses of recovery and resources appropriate for differing levels of care)
- ❖ Teamwork and delegation
- ❖ Decision-making and problem solving
- ❖ Teaching and education, including patients, family members, and professional care team members
- ❖ Conflict resolution and crucial conversations
- ❖ The ability to say "no"
- ❖ Commitment and motivation

Although the list of skills or characteristics may appear lengthy, not all will be needed for every patient, but one must assume they may be needed on any given day for any patient. Skills can be used in any combination if one is to accomplish the job, so the case manager RN or SW needs to be flexible. Competency will make a difference in how a case manager is viewed in his or her role. Competency makes a difference with how one feels about one's self and the jobs performed.

The following standards were developed by The Center for Case Management and provide case managers guidance for planning each day:

1. Support nationally published patient rights and dignity
2. Provide accurate factual information regarding the admission, communicated in a timely and accurate way to all members of the current treatment team in acute care and the next level of care
3. Empathy for the patient or family story surrounding the admission, regardless of the insurer or third-party payer, socioeconomic status, specific circumstances that precipitated the need for care
4. Advocacy for and teamwork that directly addresses unique and individual needs
5. Coordination of timely, strategic interventions that result in outcomes that are important to the patient or family and are legal
6. Assessment within 24 hours of admission of demographics, risk stratification, and attribution if readmitted

⁶ Ibid.

- ❖ Did you have an appointment with the physician who treated you while you were hospitalized after your discharge? Were you able to keep your appointment? If not, why?
- ❖ Did you see any physician other than the one in the emergency department before returning to the hospital? If so, who and when? If not, why? Is it because you were unable to schedule an appointment?
- ❖ Did you experience difficulty understanding any self-care or medication instructions after your previous admission? Were you able to perform the necessary care? Were you able to take your medications as instructed? If not, what happened?
- ❖ Were you able to have your prescriptions filled? Did you experience a problem paying for your medications? Which pharmacy do you normally use and did the pharmacist fill the prescriptions when you presented them, or did you have to leave them and return later because the correct dosage was unavailable?
- ❖ Do you understand your medications? Do you know what each is for and when to take it?
- ❖ Do you have help at home and someone to assist you if you need it? Did they not arrive? Did something else happen?
- ❖ Do you receive any CM services from your insurance company or a disease management program? If so, did a representative call or see you after discharge?
- ❖ Did transportation problems prevent you from traveling to your physician's office, pharmacy, an outpatient program, or laboratory?

Preventing Readmissions

Readmissions have historically been a concern, but the Centers for Medicare & Medicaid Services (CMS) incentives and penalties have led to increasing emphasis. Hospitals are scurrying to make changes in how such events are handled and hopefully avoided. Consequently, this places a new task (extra efforts at screening the readmitted patient to help determine the root cause of the readmission) onto hospital staff, primarily the case managers. This also means a case manager must be competent with interviewing patients, assessing their medical needs, and identifying resources and potential risks if the right plan is not set into motion. To help prevent gaps or fragmented care that could potentially place the patient at a higher risk, the case manager must continuously monitor the patient as well as the potential plans, making changes to the plans as the patient progresses or regresses. Discharge and transition plans are subject to scrutiny when patients are readmitted. Hospitals and their

Chapter 1

CM departments must be prepared to demonstrate that readmission was due to uncontrolled medical factors rather than an inadequate plan that failed to meet the patient's needs.

Thus, the core skills and competencies of a case manager will be even more critical. This is necessary because hospitals (and the CM department) will want to show that the readmission was due to uncontrolled medical factors and not due to inadequacy of the plan to meet the patient's needs.

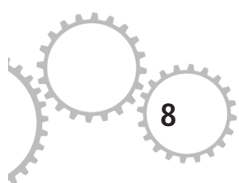
The Patient Protection and Affordable Care Act and the Hospital Value-Based Purchasing Program are sources of sweeping changes that affect hospital reimbursements. Withholding was 1% in 2013 and will increase to 2% of regular reimbursement by 2017 if hospital quality and patient satisfaction scores demonstrate a failure to meet CMS standards.

The Hospitals Readmissions Reduction Program will similarly result in withholding up to 1% of regular reimbursements for hospitals that experience too many patient readmissions within 30 days of discharge. So, what does too many readmissions mean? Basically not only are hospital admission and discharge data compared with the hospital's past history, but also hospitals are compared to one another, especially those of similar size or providing similar services. Targeted diagnoses have included heart attack, heart failure, and pneumonia; additional diagnoses will be targeted.

This program relies on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results that reflect clinical process of care measures and patient experience of care. HCAHPS is the first nationally standardized and publicly reported survey of patients, families, and their perceptions of their hospital stays and experiences. This 32-question survey and data collection tool allows valid comparison of hospitals locally, regionally, and nationally.

CMS partnered with the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality to develop and test this tool. HCAHPS surveys, which are not limited to Medicare beneficiaries, are administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Results from hospitals that provide the requisite 300 completed surveys within the required time frame appear on Medicare's Hospital Compare Web page.

Include readmitted patients in the hospital's weekly complex care/long-stay rounds. Doing so provides an opportunity for the entire team to brainstorm and determine whether other services or approaches to care might help reduce the risk of future readmission.



7. Procurement of funding and detailed arrangements for a safe, smooth, and sustained discharge or transition to the next level of care that will promote recovery, restoration, the highest level of wellness possible, or a comfortable death; i.e., provision of options to meet activities of daily living (ADL) and instrumental activities of daily living (IADL)
8. Immediate access to SW services as needed or requested for skilled support during the crisis of the hospitalization, including family meetings and decisions regarding healthcare in the future
9. Liaison between the immediate healthcare team and the insurer or third-party payer and payer regulations
10. Access to financial planning if needed or requested
11. Information about who to contact if postdischarge is needed and who will be the accountable person at the next level of care
12. Data collected from the patient or family clinical and experience with clinical management of their care will be evaluated in detail and in trended data to improve the clinical outcomes and inpatient experience of others⁷

Why Case Management Assessment Is Important

Time constraints are the reason case managers often omit face-to-face assessments and direct conversations that should be a common and daily practice for all patients, not only high-risk patients. This is particularly important when developing discharge and transition plans.

Nothing is better than a one-on-one interview with a patient or family member in the following situations:

- ❖ Discharge planning
- ❖ Transition planning
- ❖ Screening a readmitted patient

This is particularly important when screening a readmitted patient; information about what happened before the readmission is necessary to formulate a new plan. Case managers whose hospitals don't use a readmission assessment form should ask the following questions:

- ❖ What do you think caused your readmission?
- ❖ Do you have a primary care physician (PCP)? Did you see your PCP after discharge? If not, why?

⁷ The Center for Case Management, What Every Inpatient and Family Should Receive from Case Management and Social Work Services

Case managers must develop comprehensive plans for readmitted patients. Preventing readmissions has a positive effect on the following:

- ❖ Patient quality of care and life
- ❖ Patient satisfaction with the hospital experience
- ❖ Financial costs to the healthcare system

A case manager working with a readmitted patient or family members must try to identify the root cause of readmission. This can include capturing information from post-acute providers or vendors a patient used after a previous discharge. A case manager must do the following when formulating a new discharge or transition plan:

- ❖ Conduct an in-depth assessment of issues and medical needs at the time of admission and throughout the stay and determine which have been resolved.
- ❖ Identify resources that are necessary for ongoing issues (e.g., poor cognition) and include them in the final discharge plan.
- ❖ Ensure patient and/or family participation in the plan and that they understand their responsibilities as the patient progresses or regresses.
- ❖ Reconcile discharge medications with the preadmission list of medications. Educate the patient, family member, or caregiver about the medications (i.e., names of the medications, their purpose, the importance of taking medications as prescribed, and where to seek financial assistance for medications if necessary).
- ❖ Review medication use, side effects, and safety issues and use a teach-back process if medication use education was necessary.
- ❖ Develop an action plan for management of symptoms so that the patient and family members can determine whether symptom severity requires a return to the emergency department for medical care.
- ❖ Use a teach-back method if the patient, family member, or caregiver requires education for other medical care. Begin this process as ongoing care needs are identified and use the format or language that is best understood. Use written reminders, pictures, or diagrams if necessary. Discharge should not occur until professional staff members providing this education consider the patient, family member, or caregiver competent with respect to all information taught.
- ❖ Provide accurate and honest discharge information that gives a true picture of the patient and ensures that necessary care is provided.
- ❖ Schedule the first appointment with the patient's primary care physician, physician specialist, or both as soon as possible after discharge and provide this information to the patient and family members.

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- ❖ Provide the patient or family members written discharge information that is clear and legible.
- ❖ Arrange and ensure that telephone contact occurs within 72 hours of discharge. Ensure that corrective actions are taken immediately to address any issues to help prevent unnecessary readmission.

Case managers' role in the readmission process includes identifying high-risk patients within their caseloads. High-risk conditions often associated with readmission include the following:

- ❖ Patients who are frail, elderly, and older than age 85
- ❖ Elderly patients with fractures
- ❖ Patients with unexplained injuries and frequent emergency department visits
- ❖ Repeated visits due to poor pain control
- ❖ Failure to thrive
- ❖ Patients with multiple emergency department or hospital admissions (i.e., generally more than three in six months)
- ❖ Patients who require placement at discharge in a skilled nursing facility, residential care home, or another post-acute care facility
- ❖ Homeless patients
- ❖ Patients without caregivers or family support systems
- ❖ Patients who lack insurance, who have exhausted their benefits, or who have limited financial resources for copayments and deductibles
- ❖ Trauma with multiple fractures or brain injury
- ❖ History of noncompliance with their previous medical care
- ❖ History of mental illness or substance abuse
- ❖ History of chronic disease progression

Another responsibility is ensuring that documentation includes key data elements for use in the hospital's readmission report card. Some hospitals include ED visits within 30 days of discharge. Other key elements include the following:

- ❖ Notes and the discharge summary from previous admission(s)
- ❖ Last discharge date
- ❖ Readmission date (e.g., many insurers or third-party payers review all cases in which discharge and readmission occur on the same day and readmissions that occur within three days, and most insurers definitely use a 30-day marker when they review readmission data)
- ❖ Admission source (e.g., home, a skilled nursing facility, community facility)

- ❖ Readmission reason(s)
- ❖ Primary diagnosis and major comorbidities
- ❖ Case manager who performed the previous discharge
- ❖ Attending physician during the last admission
- ❖ Length of stay of the previous admission
- ❖ Length of time between the previous admission and the readmission
- ❖ Readmission primary diagnosis
- ❖ Financial class (i.e., payer vs. self-pay or uninsured)
- ❖ Service line
- ❖ Notes from the previous admission and discharge plan and resources used to determine whether a new discharge plan is necessary for the readmission

Readmissions sometimes are not preventable due to the course of the disease. An in-depth query that explores the root cause of readmission is necessary when it appears to have been preventable. The new discharge plan should incorporate resources that may help remedy any issues that are identified.

Networking and Collaboration

Internal and external networking are vital skills that new case managers should strive to develop. Create a personal directory of information about resources and relevant regulations. A hospital CM department may have a directory, but a personal print, electronic, or digital resource directory can be a real time-saver.

When a case manager learns to use his or her “network,” it will enhance work with patients and help the case manager:

- ❖ Keep abreast and current with trends, laws, regulations, and issues that impact healthcare, especially the characteristics of specific post-acute care resources
- ❖ Easily contact a manager or colleague to help sort through ambiguous situations
- ❖ Stay educated on specifics, allowing one to serve as a consultant or educator to not only the patient or family but also the multidisciplinary care team, including physicians

Hospital Case Management Models

Literature supports the fact that with the evolution of CM and the many legislative and other changes that have occurred in healthcare, providers have tried a wide variety of how CM was or is offered. Each model is dependent upon the healthcare provider, staffing, and the population served. As hospital CM services and programs have expanded, we very basically see CM falling into what is now referred to as “dyad” or “triad” models. At hospitals that use the dyad model, we see primarily an SW and nurse, each assuming specific roles and duties. Generally, this has the nurse assuming responsibility for the utilization management functions and discharge planning, while the SW assumes responsibility for any psychosocial elements and therapeutic interventions needed for patients. With the advent of emphasis placed on the business aspect and the role CM has, we now are seeing the advent of what is termed the triad model. This model basically uses three professional disciplines. This added role often focuses on such activities as clinical documentation improvement or denial management, all with a business focus to assist a hospital with protection of financial interests. Hospitals rely on dyad and triad models for staffing, roles, and deployment. Some use one model only, but others use both in various departments (e.g., dyad in the ED, triad in nursing units).

Dyad model

A nurse has the following CM responsibilities:

- ❖ Coordination of care, discharge planning, transition planning
- ❖ Appropriateness of admissions reviews, bed management, concurrent utilization management reviews, and clinical documentation improvement that involves collaboration with physicians to improve documentation quality and completeness and billing accuracy

An SW has the following CM responsibilities:

- ❖ Psychosocial assessments and interventions
- ❖ Assistance for patients classified as high risk or with complex discharge planning needs

Triad model

The triad model adds a third staff member to the team, with CM responsibilities assigned as follows:

- ❖ A nurse who performs coordination of care, discharge planning, transition planning
- ❖ An SW who provides psychosocial assessments and assistance with high-risk discharges
- ❖ A nurse who performs utilization review and/or clinical documentation improvement activities

Successful CM requires the following:

- ❖ Effective collaborative relationships between all case managers and multidisciplinary team members
- ❖ Balanced workloads, with ratios per day set per the case manager's role and responsibilities
- ❖ Leaders who are respected by the hospital's executive team

Typical Activities of an RN Case Manager

RNs serving on the CM team are frequently charged with any aspect as it relates to use of their professional nursing training. Here these skills are used as utilization management activities are performed and the patient's clinical picture is compared to nationally recognized criteria to assist in the determination of the appropriate level of care. In addition to a utilization management role, the nurse case manager also might be to serve as the clinical coordinator for the case, assisting with provision of any clinical aspects of the case that might be important to moving the patient along the continuum. Another role might be to perform all aspects necessary for discharge planning for all patients, collaborating as needed with the SW case manager on the more complex cases.

If the hospital utilizes the nurse for utilization management and the SW for any discharge planning, the nursing role is to provide the necessary data that ensure medical needs will be addressed as the discharge plan is developed and implemented.

Typical Activities of a Social Worker Case Manager

Social services is a separate department in some hospitals, and in others it is part of the CM department. SWs are a vital part of the multidisciplinary care team; they provide essential and timely services to patients and their families. Examples include psychosocial assessments, assistance with complex discharges, and linkage to community resources,

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financial resources, and support groups. They collaborate with nurse case managers and multidisciplinary team members.

SWs who are part of the CM team focus on providing emotional support related to a patient's illness, trauma, abuse, conflicts, and decision-making ability. They identify issues that can pose a barrier to a safe and timely discharge. SW case managers are invaluable team members for patients considered complex and high risk for a variety of reasons that include but are not limited to the following:

- ❖ Difficult adjustment to an illness or injury
- ❖ Major lifestyle changes
- ❖ Complex family issues and indecisiveness that thwart the discharge plan, transition plan, or treatment plan
- ❖ Prognoses that involve end-of-life issues and bereavement
- ❖ Family crises
- ❖ Advocacy and referral to entitlement programs to address legal or ethical issues
- ❖ Psychosocial issues that require referral to a psychiatrist or an inpatient psychiatric setting, evaluation of a patient's decision-making capacity, and evaluation of patients identified as abusing drugs or alcohol
- ❖ Assessment, referral, and reporting any form of abuse
- ❖ Socioeconomic assessment for financial resources or linkage to entitlements
- ❖ Adoption or surrogacy
- ❖ Crisis intervention and counseling

Figure 1.1 provides examples of nurse and SW case manager roles and responsibilities for specific case actions.

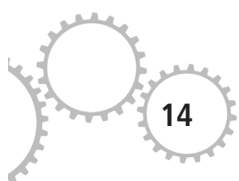
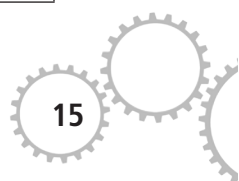


Figure 1.1 | Nurse and Social Worker Case Management Roles and Responsibilities

Typical Case Manager Responsibility Issue	Nurse	Social Worker
Patients who don't meet admission or continued stay criteria	X	
Home IV therapy	X	
Medication issues at discharge	X	X
Inpatient readmissions in fewer than 30 days	X	X
Rehabilitation candidate	X	
Skilled nursing facility candidate	X	
Home healthcare candidate	X	
Hospice candidate	X	X
Comfort care candidate	X	X
Palliative care candidate	X	X
Ethics committee	X	X
Avoidable delays identified	X	X
Noncompliance	X	X
No financial resources	X	X
No family or social support system	X	X
Case conference	X	X
Homeless and no ongoing medical needs after discharge		X
Homeless and ongoing medical needs at discharge	X	X
Involuntary hold assessment (i.e., 5150, pink slip)		X
Crisis interventions	X	X
Psychiatric diagnosis and need for resources		X
Psychiatric diagnosis and ongoing medical needs at discharge	X	X
Psychiatric diagnosis with discharge to inpatient psychiatric unit		X
Elder or dependent adult abuse, child abuse, or victim of a violent crime	X	X
Sexual assault		X
Domestic violence		X
Unintentional overdose	X	X
Attempted suicide without ongoing medical care needs		X
Attempted suicide with ongoing medical care needs	X	X
Positive drug toxic screen		X
Perinatal positive toxicology		X
Conservatorship		X
Capacity evaluation and referral to a physician or psychiatrist for decision-making		X
Psychosocial issues affecting plan for the day or stay		X
Adoptions		X
Teen pregnancies		X



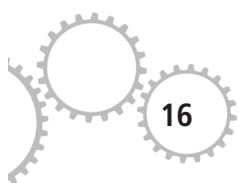
Labor, Delivery, Newborns, and NICU

The responsibilities of case managers assigned to labor and delivery, the newborn units, or the neonatal intensive care units (NICU) will differ slightly from the responsibilities of case managers working in other inpatient units. Emotions can run high in these units; meeting as a team several times daily can ensure necessary tasks are completed by day's end and simultaneously avoid duplication of effort. A daily meeting with unit nurses ensures that they are apprised of actions and tasks they might be required to perform.

Hospitals can experience lost revenue if case managers assigned to one of these units fails to take necessary actions, particularly for premature newborns or those with deficits. Examples of situations that require particular actions include the following:

- ❖ When a birth mother is discharged but the baby's medical condition requires a continued stay, the case manager must take additional actions, which often include working with not only the mother of the baby but also the unit's assigned patient financial services (PFS) counselor as well as possibly the unit SW. This is necessary to ensure the baby is enrolled into either the mom's or dad's insurance or Medicaid as soon as possible.
- ❖ Another is teenage mothers, where the pregnancy and delivery were covered under the teenage mom's and her parent's insurance. In cases such as this, the baby must be enrolled immediately in either an insurance of his or her own or Medicaid, as once the teenage mom delivers, her parent's insurer or third-party payer will no longer cover the baby.
- ❖ Another category is birth mothers who give up the baby for adoption and the baby stays beyond the mom's discharge. In this case, the baby must be enrolled either in Medicaid or in the new adoptee parents' health plan.

Other responsibilities include ensuring completion of a Medicaid authorization request for mothers and newborns covered by Medicaid. This varies by state and is sometimes referred to as a treatment authorization request or a service authorization request. Most hospitals complete this form daily until mothers and their newborns are discharged. Other responsibilities include making the appropriate referrals for newborns with special healthcare needs and those born with developmental disabilities as soon as possible. This entails educating the newborn's parent or parents about the importance of completing appropriate applications and program benefits.



Because patients (the mothers) in this area often have many psychosocial and socioeconomic issues, including homelessness, drug or alcohol abuse, or domestic violence, the case manager SW assigned to the unit will be one of the most critical members of the team.

Emergency Department Case Management

Historically, one SW was assigned to a hospital emergency department to assist with psychiatric patients' evaluations and placement, abuse cases, and families in crises. ED CM teams now often include SW and nurse case managers who work together to develop care coordination plans for the high ED utilizers in collaboration with patients, family members, and community team members (i.e., home health agency staff, nursing home staff, or other community agencies and their staff who might assist with patients and post-acute care).

Case manager RNs or SWs are usually assigned to specialty units or populations (e.g., trauma, spinal cord injury, orthopedic, acute rehabilitation, transplant, oncology, clinical trial, pediatrics). Their duties may differ from those of their case manager peers on other units, including:

- ❖ Reinforcement of standards of care and delivery of core measures
- ❖ Development of a very thorough and comprehensive discharge or transition plan
- ❖ Participation in physician and staff “grand rounds” and scheduling of conferences
- ❖ Teaching a presurgical class to persons who are anticipating an elective admission for the event
- ❖ Teaching and guiding the interns and medical students
- ❖ Directing the therapy staff to the appropriate durable medical equipment or medical supply provider or vendor for the ordering of appropriate supplies from the patient's insurer or third-party payer and ensuring the use of the right contracted or network provider or vendor and any specific requirements, limitations, or exclusions of the patient's specific insurer or third party-payer
- ❖ A thorough knowledge of specific forms the hospital might issue to the patient or family (i.e., Physicians Orders for Life-Sustaining Treatment, advance directives, informed consents) and then being available to answer any questions that might arise from the patient or family
- ❖ A thorough knowledge of community, local, statewide and national resources, agencies, providers, or vendors as well as public entitlement programs and patient eligibility and referral requirements for the specialty provided to the patients

- ❖ More frequent “huddling” with the multidisciplinary care team, with huddles occurring several times per day or week
- ❖ SWs may provide coverage of both a specialty unit and the related specialty clinic, offering much-needed continuity of relationships
- ❖ Participation in research and other projects

Establishing Daily Workflow

Case managers may often hear the phrase “the 80/20 rule.” What this means is that 80% of a case manager’s time is commonly consumed by 20% of his or her assigned patients. Thus, if one finds they are spending too much time on one patient, learn to be proactive and alert the CM director or manager so that help can be assigned and the tasks needing to be done for the day are completed by the day’s end.

A frequent complaint heard by a CM director is “my caseload is too heavy.” Directors are aware of the reality that not every patient needs to have something done every day, but they do need to understand that it takes time for SW and RN case managers to assess which patients and families do need some type of intervention. It will help both case managers and their manager/directors to realize that there can be a big difference between a total caseload and actual daily workload. For example, if a case manager is assigned a caseload of 20, in reality the actual “workload” for the day may be lower. In fact in most cases, the actual workload generally ranges from 10 to 12 patients that actually need an intervention on any given day. The “work performed” might be conducting a utilization management review, completing an assessment to develop a potential discharge or transition plan, or conducting a family meeting for important decisions. The authors’ advice for new case managers is to not be consumed by numbers. If one truly will be performing more duties than normal and the workload is actually a higher number and it is known all duties will not be accomplished by the day’s end, keep the CM director or manager apprised. This will allow realistic adjustments to be made to a workload.

A caseload is the total number of patients assigned to a specific case manager. Use it to prioritize a daily workload list of patients who need something that day. Understand that priorities can and often change throughout the day.

Figure 1.2 illustrates a sample list of patient needs a case manager must address on a specific day.

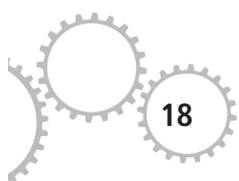


Figure 1.2 | Setting and Resetting Priorities for a Day

Patient A—Give an insurer or third-party payer a review

Patient B—Persuade physician that patient needs home healthcare and persuade the home health agency to accept the patient

Patient C—Conduct family or physician case conference to discuss outstanding care need

Patient D—Gather information and get people involved with problem solving the patient’s new medical onset of confusion

Patient E—Determine why patient was readmitted and develop plan to prevent another readmission

Patient F—Patient is an IV heroin addict who needs IV antibiotics

Patient G—Undocumented patient needs post-acute care and no funding is available

Patient H—Patient capacity determination necessary

Patient I—Family upset and threatening litigation

Patient J—Orders needed and attending physician not responding to calls or pages

Patient K—Hospitalist and consulting physician are not in agreement

Patient L—Attending physician has not seen the patient or entered a progress note for more than 24 hours

Patient M—Discharge supposedly occurred yesterday, but review of census or worksheet indicates patient remains hospitalized

Caseloads can be further prioritized when case managers arrive on units. Urgency determines priorities for a nurse case manager with responsibility for utilization management, care coordination, and discharge planning. A combination of the following rather than a linear progression provides an example:

- ❖ Use handoff information from the previous day to identify observation patients, patients scheduled for discharge today, newly admitted patients who require utilization management review (if this did not occur in the ED), patients who require concurrent review, and patients who should receive the Important Message from Medicare (IM) because discharge is anticipated within two days.
- ❖ Review patients’ medical records and note discharge orders for today, which serve as an alert for related necessary tasks.

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- ❖ Call attending physicians on the patient census to determine their plans for the day for their patients and begin preparing for the unit's daily multidisciplinary care coordination rounds.
- ❖ Huddle with other case managers, the unit's clinical director, and the unit's assigned patient financial services counselor to identify key issues that require immediate attention and delegate responsibility. Negotiate everyone's daily workload
- ❖ Complete all observation reviews first if assigned to a general medical–surgical unit. Observation is billed hourly, and some hospitals require reviews every eight hours to identify patients who meet inpatient criteria. This and the 2-midnight rule affect reimbursement.
- ❖ Complete any tasks related to known discharges.
- ❖ Complete any insurer or third-party payer reviews, which generally are due by noon, so that their medical directors can make coverage determinations and issue approvals or denials.
- ❖ Complete any new admission reviews. This includes chart review to determine whether the patients meet criteria for inpatient admission or observation level of care. It also includes a preliminary patient interview or assessment to obtain medical history, prior level of functioning, and initial discharge or transition plans. Notes taken during the initial utilization management review facilitate development of a discharge or transition plan.
- ❖ Notify CM clerical staff when reviews are completed so they can fax them to insurers and third-party payers.
- ❖ Complete continued stay reviews. Review orders, progress notes, therapy notes, laboratory values, and imaging results to ensure that patients continue to meet inpatient criteria.
- ❖ Communicate with unit physicians as needed throughout the day in person, by telephone, or by email. Adhere to hospital policy when transmitting protected health information via email.
- ❖ Communicate with the multidisciplinary team as needed throughout the day and to prepare for daily care coordination afternoon rounds.
- ❖ Update clerical staff with respect to Medicare patients who must receive the IM letter.
- ❖ Participate in daily multidisciplinary care coordination rounds.
- ❖ Document events as they occur. Document handoff communications for the next day or next case manager.

Hospitals sometimes have tools that record tasks that must be accomplished on a particular day. Case managers often develop worksheets they can use to identify these tasks.

Figure 1.3 provides a sample daily priority worksheet.

Figure 1.3 | Sample Worksheet

Room	New Admission Assessment	Observation (New)	Observation (24 Hours)	Discharge Today	Discharge within 2 Days	IM Letter	Continued Stay Reviews	Case Conferences	Other

The Handoff Process

A handoff process that includes documenting and updating actions that have been taken or that are needed is essential.

Document information in the CM portion of patients’ medical records. Include information about discharge plans, names and telephone numbers, and information about activities that have been initiated. Such documentation saves time and prevents unnecessary extra work for colleagues.

The SBAR technique developed by Kaiser Permanente in Colorado provides a good framework for handoff communications:

- ❖ S—Subjective
- ❖ B—Background
- ❖ A—Assessment
- ❖ R—Recommendation

Refer to Figure 1.4 for an example of SBAR documentation.

Figure 1.4 | Sample SBAR Documentation

S: Family: “We can take care of Dad without any help once he is discharged.”

B: Patient has a diagnosis of pancreatic cancer with a new diagnosis yesterday. He has metastatic lesions on his spine. Pain scale is 10 and he is not eating. Patient and family have been told of diagnosis but they have not met with the physician yet.

A: This family has had several deaths during the past year, most recently the patient’s wife six months ago. They need time to get more information and make plans. Patient requires an effective pain and nutrition regimen.

R: Palliative care consultation.

Best Practices

- ❖ Learn to be flexible and, for difficult or challenging patients, learn to think outside the box
- ❖ Learn to be proactive and not a passive participant
- ❖ Remember, as plans are developed, they must be patient centered and individualized; there is no cookie-cutter plan that fits all

References

Case Management Monthly. “Delegation in case management: Techniques to save your time and sanity.” March 2009, vol. 6. Danvers, Mass.: HCPro, a division of BLR.

Cesta, T, Cunningham, B. 2000. *Core Skills for Hospital Case Managers, A Training Toolkit for Effective Outcomes*. Danvers, Mass.: HCPro, a division of BLR.

Daniels, S. 2011. Introducing HCM v3.0, *A Standard Model for Hospital Case Management Practice*, vol. 16. Phoenix, Ariz.: Lippincott Williams & Wilkins.

Owen, M. 2010. “Professional Case Management, The Leader in Evidence Based Practice,” p. 45–46. *The Heartbeat of Case Management—Now Is the Time*, vol. 15, no. 1. Phoenix, Ariz.: Lippincott, Williams & Wilkins.

Rossi, P. 2003. *Case Management In Healthcare*, 2nd ed. Philadelphia: W.B. Saunders Company.

Walsh, K, Zander, K. 2007. *Emergency Department Case Management, Strategies for Creating and Sustaining a Successful Program*. Danvers, Mass.: HCPro, a division of BLR.

Zander, K. 2008. *Hospital Case Management Models, Evidence for Connecting the Boardroom to the Bedside*. Danvers, Mass.: HCPro, a division of BLR.

Zander, K. 2011. *What Every Inpatient and Family Should Receive from Case Management and Social Work Services*. Wellesley, Mass.: The Center for Case Management.

THE HOSPITAL CASE MANAGEMENT ORIENTATION MANUAL

Peggy A. Rossi, BSN, MPA, CCM

Reviewed by Karen Zander RN, MS, CMAC, FAAN

The Hospital Case Management Orientation Manual provides comprehensive information to help new and experienced case managers face the myriad of challenges that comprise a typical day.

It offers advice for locating community resources and includes examples of how to document information. The online appendix provides links to websites with helpful information.

This book is simultaneously a teaching tool for new case managers and an essential resource for seasoned professionals.

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