

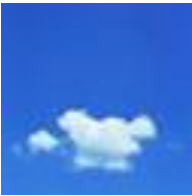


Rural Hospital Case Management

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Principal

STROUDWATER ASSOCIATES

The participant will be able to:



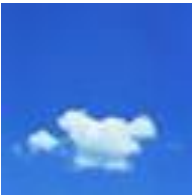
- ❖ Verbalize key responsibilities of a Case/Care Manager
- ❖ Discuss processes to ensure success
- ❖ Quantify data to assist her/him with managing acute care, observation and swing bed services
- ❖ Identify new crucial tasks associated with continuum of care



What is Case Management

What is Case Management?

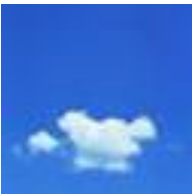
- Case Management Society of America (CMSA) defines care managers as:
 - Advocates who help patients understand their current health status, what they can do about it and why those treatments are important.
 - Care managers are catalysts by guiding patients and providing cohesion to other professionals in the health care delivery team, enabling their clients to achieve goals more effectively and efficiently.





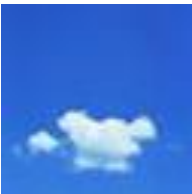
Case Management Roles

- *The Standards of Practice for Case Management were last revised in 2010* which provides voluntary practice guidelines for the case management industry.
- The *Standards of Practice* are intended to identify and address important foundational knowledge and skills of the case manager within a spectrum of case management practice settings and specialties.
- The 2010 Standards reflect many changes in the industry, which resonate with current practice today. Some of these changes include the following:
 - Minimizing fragmentation in the health care system
 - Using evidence-based guidelines in practice
 - Navigating transitions of care
 - Incorporating adherence guidelines and other standardized practice tools
 - Expanding the interdisciplinary team in planning care for individuals
 - And improving patient safety
- CMSA believes that these are all important factors that case managers need to address in their practices.



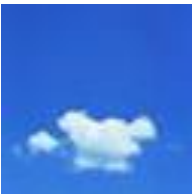
❑ **“Medically-related social services”** means services provided by the facility’s staff to assist patients in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services could include:

- Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;
- Maintaining contact with family (with patient’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;
- Assisting staff to inform patients and those they designate about the patient’s health status and health care choices;
- Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);
- Assisting patients with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);



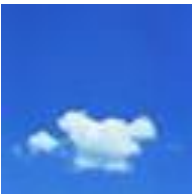
❑ “Medically-related social services” – continued

- Discharge planning services (e.g., helping to place a patient on a waiting list for community congregate living, arranging intake for home care services for patients returning home, assisting with transfer arrangements to other facilities);
- Providing or arranging provision of needed counseling services;
- Assisting patients to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;
- Finding options that meet the physical and emotional needs of each patient;
- Meeting the needs of patients who are grieving; and
- Assisting patients with dental/denture care, podiatric care; eye care; hearing services, and obtaining equipment for mobility or assistive eating devices.



Case Management Roles/Tasks

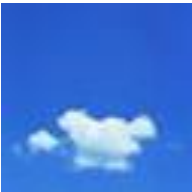
- Utilization Review
- Pre-Certification Process
- Liaison between patient/family and physicians
- Contact for referral sources
- Swing Bed Coordination in most rural hospitals
- Discharge planning with knowledge of community resources
- Data gathering for core measures and other quality indicators
- May participate in concurrent coding



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Staffing

- Most rural hospitals have 1 case manager/swing bed coordinator which also includes the UR tasks
- Some rural hospitals have a social worker to assist with the role above as discharge planner
- Some have a UR nurse and a Discharge Planner
- Some use the DON to perform the above
- Others (but few) have a person for every role
- When more than one person – most often not from one department!!!!



Relationship

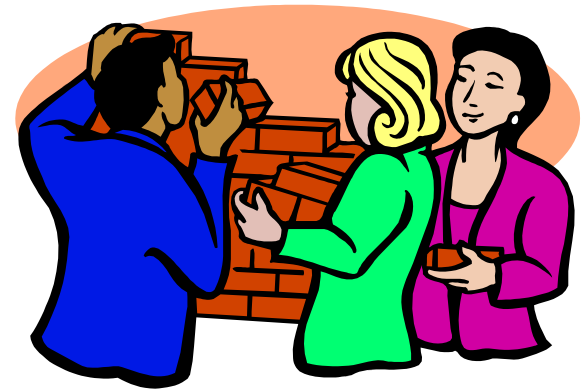
- Crucial to have a people person





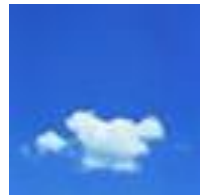
Process

- Success depends on communication
 - Physicians
 - Patient
 - Family/Significant Other
 - Nursing
 - Therapists
 - Registration
 - Business Office - Biller
 - HIM - Coder
 - SB referring sources
 - All hospital departments (ED/Lab/Radiology)

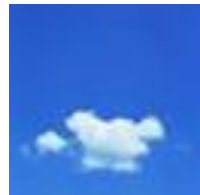


- Requires organization
 - Review of new admissions face sheet
 - Determine where to start
 - Work with admissions to determine the pre-cert/cert needs for payors based on priority
 - Review patient placed in Observation as early as possible
 - Review Medicare charts for appropriate criteria to ensure that the right patient is in the right bed
 - Identify discharge planning and which case requires communication with the physician
 - Who should round with the physician(s)
 - Stand-up meetings
 - Swing bed coordination begins a few days prior
 - Facilitation of SB interdisciplinary team

- Let's discuss relationship with physicians.....



- Requires know-how
 - Grasp of admission criteria guidelines
 - What and when to give the important message from Medicare (IM)
 - Admission
 - 2 days prior to discharge (no less than 4 hrs) including for swing bed transfers
 - Notice of non-coverage within 2 days of SB discharge to a lower level of care or for those not meeting criteria
 - Requires knowledge of Observation regulations
 - Requires knowledge of SB utilization
 - Documentation requirement from physicians to support the level of care
 - Ideal is to have some understanding of coding
 - Track or know the quality indicators we are tracking such as core measures to alert directors when data not available

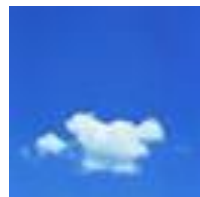


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Data Tracking

What should be tracked

- Acute admissions and days/month
- Swing bed admissions and days/month
- Acute and SB ALOS
- Observation admission and days/month as well as ALOS
- # of SB referrals by hospitals
- # of admission and refusal by hospital
- # of Observation patients who are admitted
- Reason for refusal to admit a SB
- # of IP changed to Observation
 - Not meeting criteria or
 - Clerical issue
- Readmission within 30 days post discharge from acute
- Readmission within 30 days post discharge from SB
- Diagnosis of patients being re-admitted
- Discharge placement
 - Correct information to prevent denials
 - % to where especially for SB



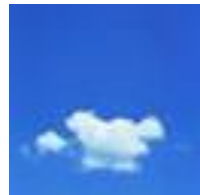
What support do we need

- CEOs/Administrators must understand the need for case management
- CEO/Administrator to support their role with physicians
- InterQual / Milliman Roberts
- Access to CMS list-serve
- Continuing education
- Coding training
- Without a team, WE WILL FAIL
- One person can't do it all
- Requires support from DON when issues are identified

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Continuum of Care

- CMS currently does not pay for a readmission on the same day as a discharge, unless it's for an unrelated reason.
- The new law reaches further, directing Medicare to recover payments made for unnecessary readmissions within 30 days of discharge after a stay for one of three conditions: heart attack, pneumonia, and/or heart failure. In the first year, a hospital's total Medicare payments can be reduced by up to 1 percent. The cap rises to 2 percent the next year, and 3 percent the third year. CMS intends to eventually add more diseases to the list.
- Then there is the potential for:
 - Bundle payment and
 - Accountable Care Organization (ACOs)



Food for thought!

- If Accountable Care Organizations (ACOs) are poised to enhance quality, improve efficiency and reduce costs will we not have to totally change how we do business?
- Is the department of tomorrow to look more like a Continuum of Care Department?
 - UR, Case Manager, SW will need to work closely together with the nursing staff
 - Discharge planning will need to be very specific
 - Discharge teaching will have to start well before the time of discharge
 - Follow-up care will be required especially for those we doubt will follow instructions
 - We will need to improve discharge planning for certain disease entity
 - Will care management be more involved on an OP basis?



Team Approach Will Be A Pre-Requisite To Success

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