AHC Media

December 7, 2016

Prioritize Patient Needs at Every Level

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Faculty

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses Transitioning Care" and her newest book: "Core Skills for Hospital Case Managers."

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

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OBJECTIVES

1. Coordinate patient transition between healthcare systems and settings such as hospital, rehabilitation, and home.
2. Demonstrate strategies for involving the patient and family in decisions regarding care and transitional options.
3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
4. Evaluate case management protocols and penalties.

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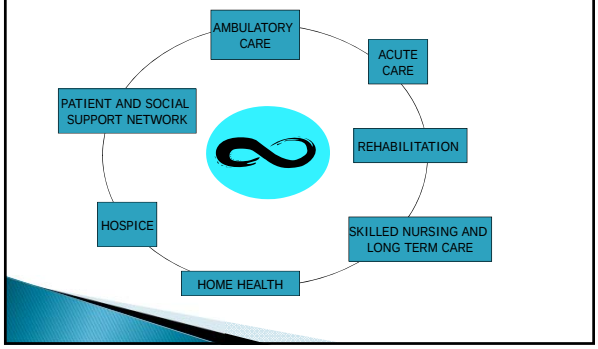
THE CONTINUUM OF CARE – NO BEGINNING AND NO END



DEFINITIONS – THE CONTINUUM OF CARE

- In medicine, describes the delivery of health care over a period of time. In patients with a disease, this covers all phases of illness from diagnosis to the end of life.
- A concept involving an integrated system of care that guides and tracks patient over time through a comprehensive array of health services spanning all levels of intensity of care.

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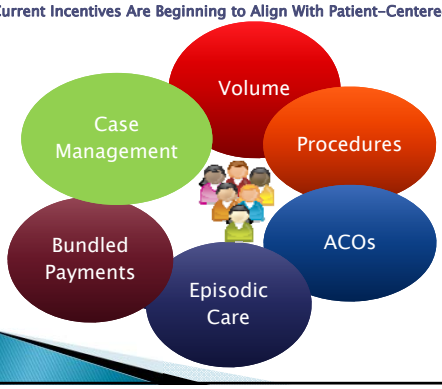
WHERE WE ARE TODAY

Current Incentives Are Beginning to Align With Patient-Centered Care.



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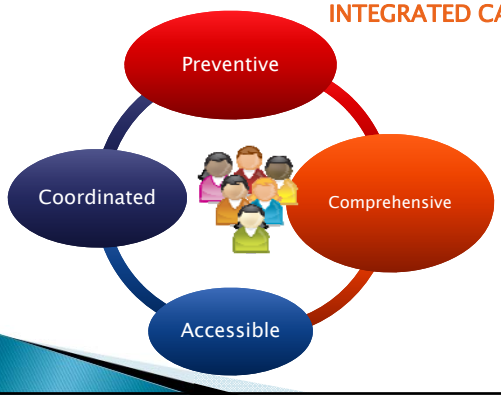
WHAT WE WANT

PATIENT-CENTERED, INTEGRATED CARE



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COMPONENTS OF INTEGRATED CARE ACROSS THE CONTINUUM

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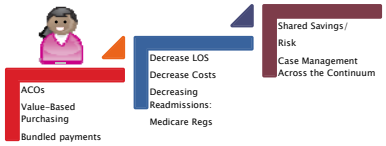
PROGRESS TOWARD POPULATION MANAGEMENT



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CASE MANAGEMENT

- Is the glue that holds the continuum of care together
- Integrated care cannot happen without it
- Case managers must be at all transition points
- Case managers must link across all healthcare settings and providers

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TRANSITIONAL PLANNING

Process in which a systematic approach is used to facilitate the transition of the patient from one level of care or setting to another

- Planning stay from door to door
- Collaboratively determining level of care
- Connecting post-acute care services
- Transitioning patients to next level of care
- Transitional planning = patient flow optimization

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IT'S ALL ABOUT TRANSITIONS. . . . . .

And affective transition is the core business of hospitals—and a core responsibility of the case management department

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DEFINITIONS

SEAMLESS → TRANSITION

- Perfectly consistent
- Continuous or flowing
- Having a surface free from roughness or bumps or ridges or irregularities

- State or passage from state or stage to another
- Alteration of a physician system from state, or condition, to another
- Shifting gears
- Passage from one phase to another

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CASE MANAGER ROLE – REGARDLESS OF SETTING

A Case Manager's responsibilities include the following functions:

- Advocacy & Education – ensuring the patient has an advocate for needed services and any needed education.
- Clinical Care Coordination/Facilitation – coordinating multiple aspects of care to ensure the patient progresses.
- Continuity/Transition Management – transitioning of the patient to the appropriate level of care needed.

American Case Management Association, 2002

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- Utilization/Financial Management – managing resource utilization and reimbursement for services.
- Performance & Outcomes Management – monitoring, and if needed, intervening to achieve desired goals and outcomes for both the patient and the hospital.
- Psychosocial Management – assessing and addressing psychosocial needs including individual, familial, environmental, etc.
- Research & Practice Development – Identifying practice improvements and using evidence based data to influence needed practice changes.

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DELIVERY SYSTEMS – NO MORE SILOS !

- Hospital visits
  - Rounding
  - Case Management
  - Social Services
  - Patient Navigators
  - Patient Advocates
- Planned Visits based on guidelines
  - Scheduling for labs before appointment
  - Group Visits
  - Telemedicine Visits
- Continuity
  - Prompts for specialty contacts
- Follow-up
  - Case Management (In-Patient, Face-Face, Telephonic, Home Visits)
    - Nurse Case Managers
    - Social Workers
  - Patient Navigators
  - Community Health Outreach Workers

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DISCHARGE PLANNING IS A PROCESS – NOT AN EVENT

And it happens at all levels across the continuum of care!

Sometimes it seems as though discharge from the hospital happens all at once, and in a hurry. But discharge planning is a process, not a single event.

From "A Family Caregiver's Guide to Hospital Discharge Planning"
www.caregiving.org

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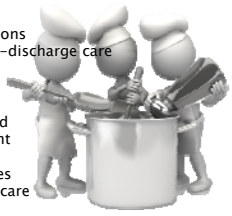
CASE MANAGEMENT IN-PATIENT TRANSITIONS



- Case finding
- Patient assessment
  - Functional ability
  - Co-morbidities and complications
  - Environmental barriers to post-discharge care
  - Services needed by patient
- Resource assessment
- Goal setting
  - What needs to be accomplished
  - Time frame for accomplishment
- Planning
  - Coordination with all disciplines
  - Coordination with all levels of care
- Implementation
- Notification of discharge appeal rights
- Monitoring/reassessment; continued interdisciplinary coordination
- Documentation

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EDUCATE KEY STAKEHOLDERS ABOUT PATIENT STRATEGIES TO MANAGE HIGH RISK/HIGH COST PATIENTS

- Key characteristics of complex patients
- Stakeholder role in complex patients
  - Planning for discharge
  - Communication with families
- Documentation regarding complex patients
  - RN and Social Worker case management documentation
    - Where
    - When
  - Key stakeholder documentation
    - Where
    - When

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- Patient/family conference process—these patients are not a part of care coordination rounds
- Notification process for any change in the complex patient: clinical, financial, family dynamics
- Rounding process
- Report to next level of care
  - Case management staff
  - Ancillary service staff
  - Nursing staff
  - Physician(s)
- Key stakeholder responsibilities

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HAND-OFF COMMUNICATION

- Ensure that this information is shared across the continuum of care
  - Written
  - Electronic
  - Verbal

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EFFECTIVE CASE MANAGEMENT AT ALL TRANSITIONS

- Admission case manager
- ED case manager
- Peri-operative case manager
- In-patient case manager
- Community case manager
  - Patient-Centered Medical Home
  - Home Care
  - Long-term care

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TRANSITIONS CASE MANAGER

- Follows high risk patients while in the hospital and during the first thirty days after discharge in the community
- Community patients followed telephonically
- If community case manager available, interfaces with the CM as well as the primary care provider, home care, etc.
- Assesses patients for high risk criteria
  - Frequent readmissions
  - Specific diagnoses – particularly chronic conditions

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COMPONENTS OF CASE MANAGEMENT TRANSITIONS

- Input
- Throughput
- Output

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TRANSITION COMPONENT #1: INPUT

- Transfers-In
- Patients Waiting For Admission
  - ED
  - Admission Office (scheduled and non-scheduled)
  - Physician Office
  - Radiology Special Procedures or Cath Lab
  - Surgical sites such as ambulatory surgery, same day surgery
  - Outpatient clinic
- Long term care settings
  - LTAC
  - Nursing Home
  - SNF
- Acute Rehab

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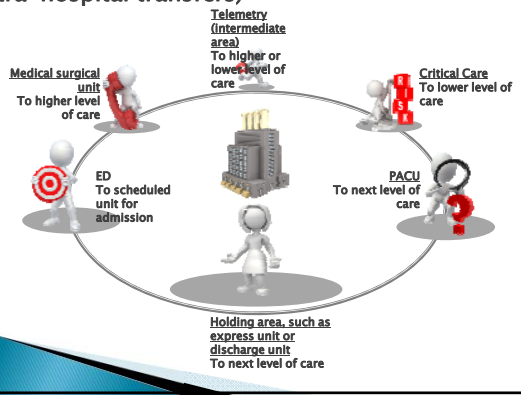
TRANSITION COMPONENT #2: THROUGHPUT (intra-hospital transfers)



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TRANSITION COMPONENT #3: OUTPUT

- Transfers to another acute care hospital
  - Higher level of care
  - Lower level of care
  - Reverse NICU transfer
  - Psych
- Discharge to next level of care facility
  - LTAC
  - Rehab
  - SNF
  - Nursing Home
- Discharge to next level of care
  - Home Care
  - DME
- Discharge home
- Referral for services not provided at your facility

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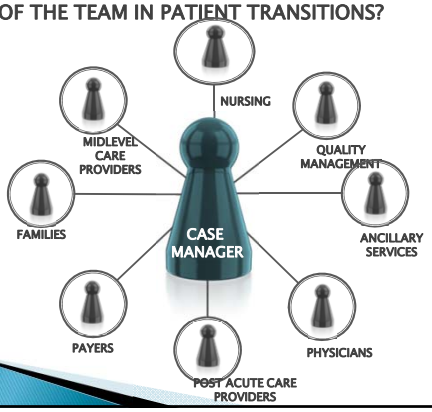
DOES YOUR CASE MANAGEMENT DEPARTMENT WORK AS PART OF THE TEAM IN PATIENT TRANSITIONS?



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DESIGNING CASE MANAGEMENT AS AN "ACROSS THE CONTINUUM" MODEL

- Create one seamless department
  - In-patient
  - Community
- Have a director for each level who both report to the same person/department
- Consider in-patient as episodic
- Manage high risk patients from the community
- Provide hand-offs as patients transition across the continuum
- Create one single database for all patients

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HEALTHCARE REFORM'S ANSWER TO TRANSITIONS: THE ACCOUNTABLE CARE ORGANZIATION

- ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals and long-term care facilities
- The goal is to deliver seamless, high quality care where patients and providers are aligned partners in care decisions

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ACO KEYS TO SUCCESS

- Strong primary care foundation
- Accountability for quality, patient experiences, outcomes and costs
- Informed and engaged patients
- Commitment to the community
- Accountability and performance as criteria for entry and participation

Source: The Commonwealth Fund Commission on a High Performance Health System

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ACO KEYS TO SUCCESS

- Multipayer alignment to provide appropriate and consistent incentives
- Payment that reinforces and rewards high performance
- Innovative payment methods and organizational models
- Timely monitoring, data feedback and technical support for improvement

Source: The Commonwealth Fund Commission on a High Performance Health System

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ACO FOCUS: LINKS THE AMOUNT OF SHARED SAVINGS TO QUALITY MEASURES IN FIVE DOMAINS

1. Patient/caregiver care experiences
2. Care coordination
3. Patient safety
4. Preventive health
5. At-risk population/frail elderly health

65 total quality measures for ACOs to report:
All defined by the National Quality Foundation

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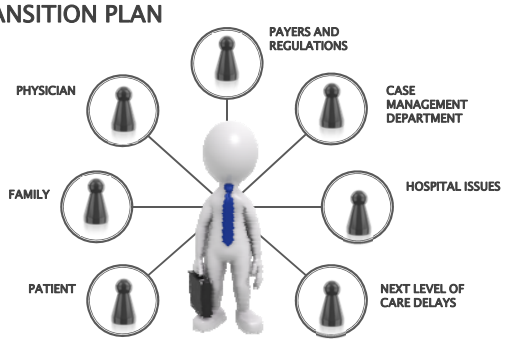
INFLUENCES ON THE PATIENT'S TRANSITION PLAN



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INFLUENCES ON THE PATIENT'S TRANSITION: PATIENT/ FAMILY

- Agreement with plan
- Perception of word "discharge"
- Timeliness in decisions
- Decision making process, including end of life decisions
- Family dynamics
- Geography

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INFLUENCES ON THE PATIENT'S TRANSITIONS: PHYSICIAN

- Planning
- Perception of the word "discharge"
- Critical thinking skills
- Financial incentives for timely transitions
- End of life communication with family
- Delays (consultants)
- Hospitalist impact
- Investment in post acute care facility/pr r

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INFLUENCES ON THE PATIENT'S TRANSITIONS: PAYER AND REGULATIONS

PAYER

- Managed care
  - Choice of vendors for next level of care
  - Delays, especially with DRG reimbursed patients
  - Timeliness of next level of care approvals
  - Timeliness of on-site reviewers
  - Contractual agreement or requirements
- Type of reimbursement, i.e. DRG/Per Diem
- Delegated review to facility
- Self pay/flat rate 'gone bad"
- Choice: patient or payer

REGULATIONS

- Balanced Budget Act of 1999: The hospital, as part of the discharge planning process must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post hospital care services and must, when possible, respect patient and family preferences when they are expressed
- Medicare Discharge Notification Appeal
- 1-2 day stays – Observation
- QIO areas of focus

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INFLUENCES ON THE PATIENT'S TRANSITION: CASE MANAGEMENT DEPARTMENT

- Processes, including delays
- Staffing Model
- Case Manager/Social Worker Relationships
- Case Manager or Social Worker
  - Critical thinking skills
  - Sense of urgency
  - Case management intelligence
  - Skill sets
  - Work load
- Manager/Director
  - Outcomes focused
  - Data driven/influenced
- Lack of integration

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INFLUENCES ON THE PATIENT'S TRANSITION: HOSPITAL ISSUES

- Scheduling of services
- Delays in services
- Hospital acquired conditions
- Patient safety events
- Communication among team
- Incomplete documentation
  - Physicians
  - Nurses
  - Other team members
- Collaboration and collaboration delays by not having:
  - Huddles
  - Interdisciplinary care conferences
  - Interdisciplinary team conferences
- Ineffective hospitalist service

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INFLUENCES ON THE PATIENT'S TRANSITION: NEXT LEVEL OF CARE ISSUES

- Appropriate use of next level of care (i.e. LTAC, hospice, palliative care)
  - Physicians
  - Family
  - Patient
  - Payer
- Next level of care providers
  - Nursing home use of SNF days
  - Not accepting patients on the weekends
  - HH delays in seeing patient
  - Delay in DME delivered to patient

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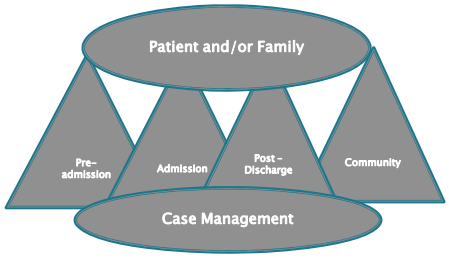

ALIGN BEST PRACTICE TRANSITION PLANNING STRATEGIES ALONG THE CONTINUUM

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ACCESS POINT CASE MANAGEMENT IN ADMITTING DEPT

- Provides gate keeping function for
  - Planned admissions
  - Urgent admissions
  - Direct admissions
  - Transfers
- Provides discharge planning to prevent social admission

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ACCESS POINT CM IN THE EMERGENCY DEPT

1. Gate keeping
2. Coordination/facilitation of care
3. Utilization/resource management
4. Transitional planning

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INTERDISCIPLINARY IMPACT ON TRANSITIONAL PLANNING

- Bedside rounds
- Effective multidisciplinary discharge planning rounds
- Long stay care conferences
  - Identify ALOS for last 6-12 months
  - Discuss all patients with LOS > than ALOS
  - Focus on clinical case, plan of stay, payer, social issues, other relevant issues, barriers to discharge
  - Frequency: 2-3 x/week
  - Attendees: Appropriate care providers, as well as government program liaisons and/or financial counselors
  - Goal: Identify and resolve barriers to care coordination and discharge

INTERDISCIPLINARY IMPACT ON TRANSITIONAL PLANNING

- Unfunded/underfunded care conferences
  - LOS
  - Discharge planning
  - Focus on compromised funding
    - Poor paying insurance policies
    - Medicare patients close to, or in LTR days
    - Medicaid patients exceeding their span of illness days
    - Medicare patients with SNF days close to end or gone
    - Flat rate patients with procedure complications
- Patient/family care conferences
- Connect patients to out-patient services to decrease readmissions
- Discharge lounge

DISCHARGE TIME OUT

- Discharge time out topics
  - Discharge plan
  - Challenges with effective discharge plan
  - Education
  - Core measures
  - Time for follow-up conversation
  - Medication reconciliation
  - Diet
  - DME needs
  - Code status
  - Readmission indicators
- Team meeting for discharge time out of challenging patient: social worker, case manager, discharge specialist, physician, next level of care liaison, staff nurse, pharmacist, appropriate ancillary staff, such as PT
- Document discharge time out

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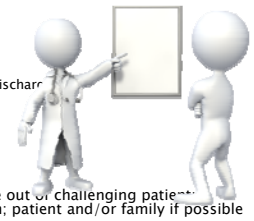
TRANSITION TIME OUT

- From one hospital level of care to another—i.e. medical unit to ICU
- From one practitioner to another
  - Intensivist to hospitalist
  - Case manager to case manager
  - Social worker to social worker
  - Nurse to nurse
- Transition time out topics:
  - Discharge plan
  - Barriers to wellness and barriers discharge
  - Clinical challenges
  - Family challenges
  - Economic challenges
  - Psychiatric challenges
  - Patient challenges
  - Avoidable/delay days
- Team meeting for transition time out of challenging patient: sending team and receiving team; patient and/or family if possible
- Document transition time out



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EXTERNAL SOLUTIONS TO DISCHARGE PLANNING ISSUES

- Community case management
  - Through your facility
  - Through partnership with community providers
  - Parish nurse programs
  - Medicaid case management programs
  - Goal
    - Empower patient and family to learn to access health care system and receive care they need
    - Provide education for healthier lifestyle
    - Decrease cost of care
    - Decrease readmissions

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DEVELOP THAT ACO PLAN MENTALITY

- Effective collaboration between hospital case management staff and next level of care provider
- Clear and concise communication
- Clear delineation of case manager and next level of care liaison roles
- Know outcomes of next level of care providers
- Offer patients a choice, but give information for to assist in making choice
- Have an alignment plan
- Manage outcomes

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COMMUNITY-BASED CARE TRANSITIONS PROGRAM

- Community-based organizations working with local hospitals and other healthcare and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from the hospital setting
- Assist patients in staying in contact with their physician, having questions answered, and coordinating medications
- Part of Partnership for Patients
- Goal: reduce preventable hospital readmissions by 20% over a 3 year period

http://www.healthcare.gov/partnershipforpatients

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COMMUNITY DESIGN

- **Team Roles & Tasks**
  - **Interdisciplinary team involved in risk assessment, guideline implementation, coordination of care and self management support**
  - **Provider discusses the importance of self-management and refers to educators/programs**
  - **Provide clinical case management services for complex patients.**
  - **Give care that patients understand and that fits with their cultural background**

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TRANSITION PLANNING OUTCOME MEASURES

- Avoidable/delay days
- % of timely assessments
- # days/% days where admission and continued stay medical necessity not met
- LOS, trends and benchmarks--severity adjusted

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TRANSITIONAL PLANNING OUTCOME MEASURES

- Referrals to providers
  - # referred
  - # and % accepted (by payer)
  - # and % declined (by payer)
  - # charity cases accepted
  - % of charity cases to total referrals
- Discharge destination code percentages, trended by year
- Physician advisor referrals
  - Interventions
  - Interventions resulting in decreased LOS

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TRANSITIONAL PLANNING OUTCOME MEASURES

- Patient satisfaction with discharge plan
  - During the hospital stay did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- Patient complaints
- Readmission for complication of discharge plan
- Discharge time (variance from goal time developed by Patient Flow Team)

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TRANSITIONAL PLANNING OUTCOME MEASURES

- Regulatory Compliance
  - Choice letter compliance
  - Important message from Medicare compliance
    - % patients receiving first letter
    - % appropriate patients receiving second letter
    - % patients requesting an appeal, but not appealing (due to case manager intervention)
    - % patients appealing
      - % appeals upheld by QIO
    - # avoidable days (based on appeals not upheld by QIO)

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TIPS FOR PATIENTS AND FAMILIES
FROM WWW.CAREGIVING.COM

Keep a special notebook with all the names and phone numbers of people who are involved in your relative's hospital care and discharge plan. You can also write instructions and referrals you will need later.

A notebook with pockets is especially handy for keeping business cards and information sheets.

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TIPS FROM WWW.CAREGIVING.COM

Tip: Discharge planning is a short-term plan to get your relative out of the hospital. It is not a blueprint for the future

Tip: It is a good idea to start thinking about discharge options as soon as the outcome becomes a little clearer

Tip: A caution: If someone tells you "Medicare" – or another insurance – "won't pay for it," don't stop there. Check it out yourself through your State Health Insurance Assistance Program (the phone number is in the back of the "Medicare and You" handbook), the Medicare Rights Center (212-869-3850, or online at www.medicarerights.org), or another independent source.

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TIPS FROM WWW.CAREGIVING.COM

Tip: Keep written records of every conversation about financial matters, whom you spoke to, what they said, and when they said it. Insurance coverage decisions are often flexible. You may need to document interpretations you have been given by different people. This is a task that another family member may be willing to take on.

Tip: With the help of an experienced health care provider or family caregiver, make a list of all the tasks that will have to be done when your relative leaves the hospital. Then make a list of all those that you can do. The third list should be people and services that can provide the care that you cannot do alone.

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HANDLING TRANSITIONS – PATIENTS AND FAMILIES

- Can be upsetting, disruptive, confusing
- Each transition brings:
  - New providers
  - New rules and regulations
  - New financial requirements
  - New care plans

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THE LONG HAUL

- Caregiving may not be a short time period – could go on for years instead of months
- Remind them to know their
  - Strengths
  - Limitations
  - And to be flexible

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Questions to be addressed Prior to Hospital Discharge (Case Management Adherence Guidelines 2006)

1. What is wrong with me & what will this condition mean to my long-term health?
   - Ability to function
   - Increase susceptibility to other health problems
   - Factors that influence my condition
   - Factors that decrease recurrence or worsening

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Questions to be addressed Prior to Hospital Discharge (CMAG 2006)

2. What do I need to do when I get home to treat my condition?
   - Follow Up appts or tests that need to be scheduled (who, what when, where)
   - Follow up visits on a regular basis
   - Transportation to get to my appts
   - Special Diet
   - Exercise restrictions
   - Return to work

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Questions to be addressed Prior to Hospital Discharge (CMAG 2006)

3. Who should I contact if I have questions regarding my treatment after I am discharged?

4. What are the things that I need to watch for to know if my condition is getting worse and what should I do if these occur? Disease Specific Checklist

5. How will I pay for my outpatient medical services?
   - treatments and tests covered by my insurance?
   - meds covered by insurance?
   - can patient receive and pay for services if not covered
   - are there programs available to help pay for medical services and treatments

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SUCCESSFUL CASE MANAGEMENT: ADMISSION PROCESS

Task	Assessment	Date	Reviewer	Notes
Pt has ability to read, understand & act on health info				
Pt understands reason for admission				
Med Review: Name & Instruction Reason for use Benefit of med Side Effects & Monitoring Adherence assess Technique review OTC product use				

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SUCCESSFUL CASE MANAGEMENT: IN-PATIENT STAY

Task	Assessment	Date	Reviewer	Notes
Pt understands basic medical condition & what factors can influence				
Pt Care Plan				
Med Review: Name & Instruction Reason for use Benefit of med Side Effects & Monitoring Adherence assess Technique review OTC product use				

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SUCCESSFUL CASE MANAGEMENT: TRANSITION

Task	Assessment	Date	Reviewer	Notes
Pt understands basic medical condition & what it means to long-term health				
Med Review: Name & Instruction Reason for use Benefit of med Side Effects & Monitoring Adherence assess Technique review OTC product use				
Self-Monitoring of Condition, Therapy Or Tx recovery				

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SUCCESSFUL CASE MANAGEMENT: TRANSITION

Task	Assessment	Date	Reviewer	Notes
Lifestyle Review: Exercise, Diet, Smoking				
Support/Follow Up Contacts				
Patient understands transition plan for care in post discharge setting Patient perceived barriers to treatment				

Case Management Adherence Guidelines, 2006

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SUCCESSFUL DISCHARGE

- Educate the patient on their disease process and factors that can influence their condition
- Ensure the patient understands and has the resources to manage their disease after discharge from the hospital
- Ensure a “safe” discharge
- Ensure the patient understands the plan for transition of care into the post discharge setting
- Ensure the patient has access to the follow up care and therapy

CMSA, 2006

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THE COMMUNITY TEAM MEMBERS

- Nurse Case Manager
- Social Worker
- Patient Advocate
- Patient Navigator
  - Community Health Outreach Worker

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NURSE CASE MANAGER OR SOCIAL WORKER

- Nurse Case Managers and Social Workers work collaboratively
- Nurse Case Managers tend to direct their work on high risk, clinically complex patients.
- Nurse case managers provide patient education
- Social Workers tend to focus on psychosocial and financial aspects
- Social Workers provide brief counseling
- Both coordinate referrals for discharge

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PATIENT ADVOCATE

Patient Advocate. *Even Christopher Columbus would have had a tough time navigating the waters of the complicated U.S. healthcare system, and most people, especially when ill, aren't the best navigators. Enter patient advocates. They help ensure that the patient gets to see the desired specialist. They do Internet research so the patient is more informed when talking to the doctor. They educate family members on how to support the patient during a hospital stay, for example, ensuring that the pills really are meant for her. And they sort through the mountains of bills and, if necessary, negotiate fees with the healthcare provider, insurance company, or other payer. ("Medicare, how dare you refuse to pay for that surgery!")*

Ahead of the Curve: Patient Advocate
By Marty Nemko
Posted December 19, 2007 U.S. News and World Report

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PATIENT NAVIGATOR

As the health-care system grows more complicated, many people need help handling it. So a new specialty has emerged--that of the Patient Navigator (PN). The role may involve coordinating doctors' visits, maintaining telephone contact between patients and physicians, arranging rides to and from the hospital, helping with insurance forms, and even suggesting what to ask at your next appointment.

Patient Navigators Guide Us Through the Medical Maze
by Dr. Ranit Mishori
published: 03/29/2009 PARADE

Usually a lay worker or volunteer & receive some type of training for specific role.

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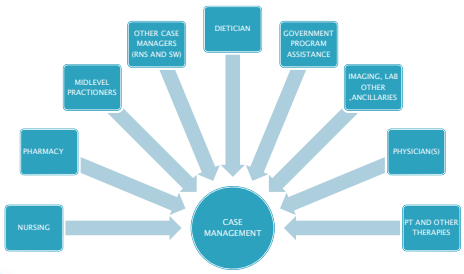
ALIGNMENT WITH KEY STAKEHOLDERS



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EDUCATE KEY STAKEHOLDERS ABOUT COMPLEX PATIENT STRATEGIES

- Key characteristics of complex patients
- Stakeholder role in complex patients
  - Planning for discharge
  - Communication with families
- Documentation regarding complex patients
  - RN and Social Worker case management documentation
    - Where
    - When
  - Key stakeholder documentation
    - Where
    - When

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DECISION SUPPORT

- **Guidelines**
  - **Provider agreement to adopt risk assessment and guidelines (Get with the Guidelines)**
  - **Triggers for high risk**
  - **Printed on forms**
- **Specialty Interaction**
  - **Referral mechanisms**
- **Provider/Staff Education**
  - **Pocket cards**
  - **Educational seminars**
- **Guidelines for patients**
  - **Wallet cards**
  - **Patient MAPS (Inpatient, Primary Care)**

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CLINICAL INFORMATION SYSTEMS

- Electronic Health Record
  - Registries
    1. Clinic registries, Disease Mgmt registries (payer, providers)
    2. Special Disease-specific templates
    3. Process flow established
  - Personal Health Record
    1. HealthVault (Microsoft)
    2. GoogleHealth (Google)
- Patient Subgroups
  - Providers and/or staff receive triggers for Disease Mgmt program (A1c – Diabetes Self-Management Referral)
- Care Planning
  - Triggers & Lists generated for those high risk (Blood glucose triggers to inpatient diabetes nurse educator)
  - Share information with patients and providers to coordinate care

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CLINICAL INFORMATION SYSTEMS

- Care Reminders/Patient Education
  - Outlier reporting to identify patients in need of tests
  - Letters and labels produced from demographic info
  - Patient Education Materials (Get with the Guidelines, Passports)

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COMMUNITY RESOURCES

- Effective Programs
  - Identifies internal and external community resources
  - Create Community Toolbox (Diabetes Self-Management Training Programs, Community Health Centers, Support Groups)
  - Provides resource booklets and placed in Toolbox
- Partnerships
  - Identifies & Utilizes community resources (health plan, health department or hospital)
  - Establish MOUs
- Coordination
  - Case Manager & Social Worker discuss resources with patient

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SELF-MANAGEMENT SUPPORT

- Emphasize Patient Role
  - Multiple providers send this message to patient (Patient report cards)
- Assessment
  - Downloaded assessment from Web site
  - Case Manager assesses patient self-management readiness (CMAG)
- Interventions
  - Providers & Staff received training through Chronic Disease Self-Management Program
- Care Planning & Problem Solving
  - Checklists & Question Templates
  - Use of motivational interviewing techniques

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SELF-MANAGEMENT ELEMENTS

- Knowledge: Health Literacy
- Compliance vs Adherence
- Self-Efficacy: Level of Confidence

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HEALTH LITERACY

- Definition: ability to read, understand, and act on health information.
- Health literacy can be present regardless of education or socioeconomic levels.
- Poor health literacy leads to med and treatment errors, and ineffective healthcare interactions

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WHAT'S THE FUTURE OF CASE MANAGEMENT?

- Acute care case managers
- Payer case management that is more involved
- Community case managers
- Electronic communication across the continuum
- Health homes for all patients
- A case management delivery system without walls

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WEB RESOURCES

- Administration on Aging www.aoa.gov/caregivers Caregiver resources from the Administration on Aging (also see Eldercare Locator below)
- Caregiving.com www.caregiving.com Online support groups and numerous articles on care giving
- Care Planner www2.careplanner.org Online decision support tool for seniors, individuals with physical impairments, and their caregivers
- Children of Aging Parents 800-227-7294 www.caps4caregivers.org Information, referrals, and support for caregivers of the elderly and chronically ill
- Eldercare Locator 800-677-1116 www.eldercare.gov Help with locating aging services in every community throughout the United States
- Family Caregiver Alliance 800-445-8106 www.caregiver.org Information on care giving, and online support groups; California-focused
- Healthfinder www.healthfinder.gov Free Internet guide to consumer health information from the U.S. Department of Health and Human Services

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WEB RESOURCES

- Medicare.gov 800-MEDICARE The official U.S. government site for people with Medicare
- National Alliance for Care giving www.caregiving.org Support for family caregivers and the professionals who serve them
- National Association of Professional Geriatric Care Managers 520-881-8008 www.caremanager.org Information on geriatric care management, and a free online care manager search tool
- National Family Caregivers Association 800-896-3650 www.nfcacares.org Support for those who care for chronically ill, aged, or disabled loved ones
- Society for Social Work Leadership in Health Care 866-237-9542 www.sswlhc.org Dedicated to promoting the principles of social work within the health care system
- United Hospital Fund 212-494-0700 www.uhfnyc.org Publisher of *Always on Call: When Illness Turns Families into Caregivers*
- Federal Register, April 7, 2011 Update of provisions in Section 302 of Affordable Care Act

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WEB RESOURCES

- Area Agencies on Aging (AAAs) Help adults age 60 and older and their caregivers. To find the AAA in your area, call The Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST), or visit www.eldercare.gov.
- Long-Term Care (LTC) Ombudsman Program Advocate for, and promote the rights of, residents in LTC facilities. Visit www.Ltcombudsman.org.
- Aging and Disability Resource Centers (ADRCs): Offer resources to help people of all incomes and ages stay independent. Visit www.adrc-tae.org.
- Centers for Independent Living (CILs): Help people with disabilities live independently. For a state-by-state directory of CILs, visit www.ilru.org/html/publications/directory/index.html.
- State Technology Assistance Project: Has information on medical equipment and other assistive technology. Call 1-703-524-6686 to get the contact information for your state, or visit www.resna.org.
- National Long-Term Care Clearinghouse: Provides information and resources to plan for your long-term care needs. Visit www.longtermcare.gov.
- National Council on Aging: Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit www.benefitscheckup.org.
- State Health Insurance Assistance Programs (SHIP): Offer counseling on health insurance and programs for people with limited income. Also help with claims, billing, and appeals. Visit www.medicare.gov/contacts/Default.aspx, or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's number. TTY users should call 1-877-486-2048.
- State Medical Assistance (Medicaid) office: Provides information about Medicaid. To find your local office, call 1-800-MEDICARE and say, "Medicaid." You can also visit www.medicare.gov.

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