



Transforming Your Case Management Department Part I

Toni Cesta & Bev Cunningham

RELIAS
LEARNING

Speakers

- **Toni Cesta, PhD, RN, FAAN**



Founding partner of Case Management Concepts, LLC. 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. She has been active in the research and development of Case Management for over 20 years.

- **Beverly Cunningham, MS, RN, ACM**



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 the former Vice President of Resource Management at Medical City Dallas Hospital.

LEARNING OBJECTIVES

- Describe best practice roles for RN case managers and social workers.
- Explain unique functions associated with each role.
- Explain how to integrate roles and functions to optimize the skill set of each discipline.

WHY CHANGE YOUR STRUCTURE NOW??

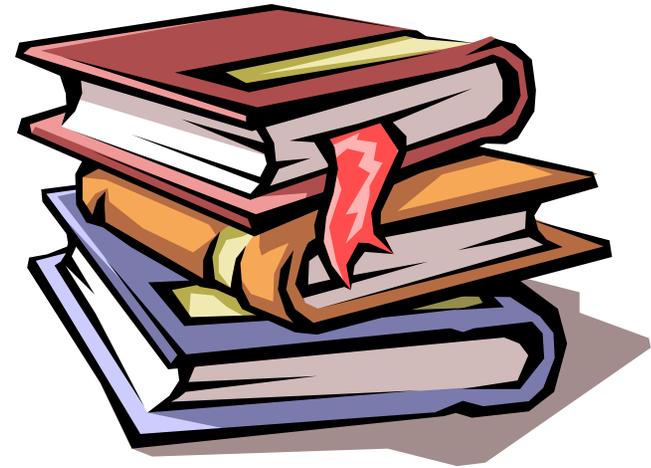
- Accelerating health care processes
- Multiple audits: RAC, MAC, ZPIC, QIO
- The Affordable Care Act
- Value-Based Purchasing
- Renewed emphasis on care transitions
- Trying to do MUCH, MUCH MORE WITH LESS

STANDARDS OF PRACTICE

- Apply to any and all roles that a case manager or social worker may be responsible for
- First standards introduced by Case Management Society of America in 1995
- Provide a foundation of the knowledge and skills that apply to the practice regardless of practice setting or discipline

COMPONENTS OF THE STANDARDS OF PRACTICE

- The definition of case management
- The Statement of Philosophy
- Guiding Principles



CMSA 2016 DEFINITION OF CASE MANAGEMENT

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.

ELEMENTS OF THE DEFINITION

- Applies to case management in a universal manner regardless of setting or discipline
- Outlines the case management process
- Describes the outcomes the case manager is responsible for achieving on behalf of the patient and family
- The foundation upon which the work of case management sits



STATEMENT OF PHILOSOPHY

Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation.....Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcomes for all concerned”

CMSA'S GUIDING PRINCIPLES FOR CASE MANAGEMENT

APPLY TO ALL ROLES AND FUNCTIONS WITHIN THE FIELD OF CASE MANAGEMENT

- Use a client-centric, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.

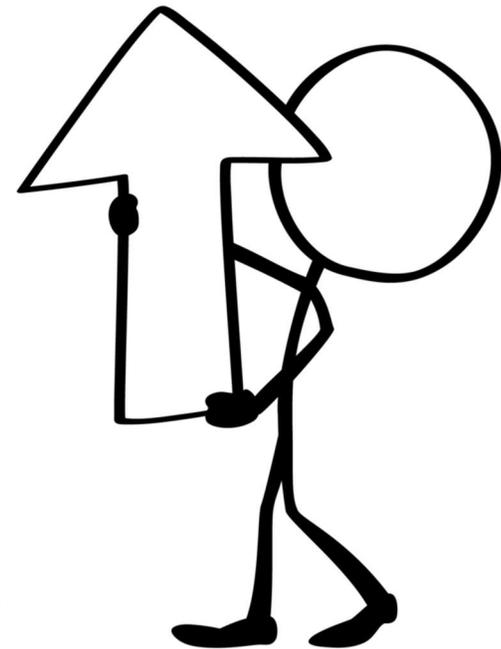


CMSA'S GUIDING PRINCIPLES FOR CASE MANAGEMENT (con't)

- Use a comprehensive, holistic approach.
- Practice cultural competence, with awareness and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal client safety.
- Promote the integration of behavioral change science and principles.
- Link with community resources.

CMSA'S GUIDING PRINCIPLES FOR CASE MANAGEMENT (con't)

- Assist with navigating the health care system to achieve successful care, for example during transitions.
- Pursue professional excellence and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organization and certification rules and regulations.



GUIDING PRINCIPLES ARE DIFFERENT FROM ROLES AND FUNCTIONS

- They apply to each and every role and function we perform
- Are not roles and functions themselves

Example:

Patient Advocacy applies to each and every role and function, regardless of setting, profession or caseload



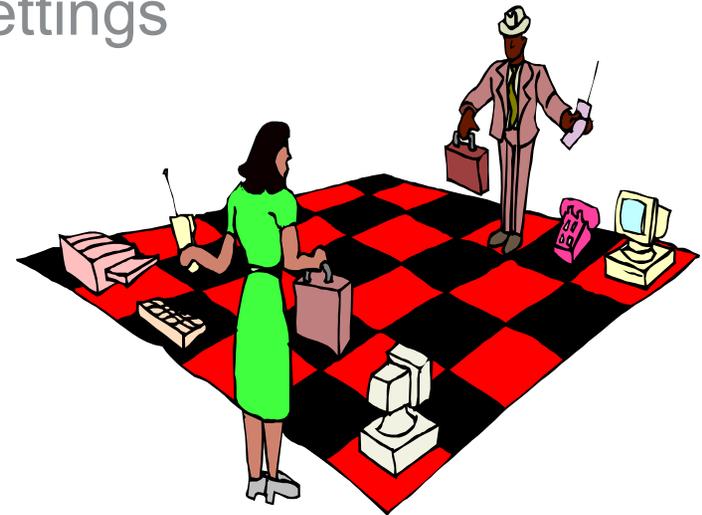
MODEL OF CARE

*A DESCRIPTION USED TO HELP
VISUALIZE SOMETHING THAT
CANNOT BE DIRECTLY
OBSERVED*

ALSO KNOWN AS AN
EXEMPLAR, EXAMPLE, IDEAL

WHAT IS A ROLE?

- The set of key categories that case managers perform
- They provide the context in which we work
- Applied differently in different settings



CONTEMPORARY CASE MANAGEMENT ROLES

- Patient flow - clinical coordination/facilitation
- Utilization and resource management
- Denial management
- Variance tracking
- Transitional and discharge planning
- Quality management
 - Core measures
 - Readmissions
 - Adverse events
- Psychosocial assessments and interventions

WHAT ARE FUNCTIONS?

- The series of activities or tasks that are conducted within each role.
- They are the specific actions taken by a case manager in the performance of the roles.
- They are needed to complete each role.
- Functions may vary from model to model.



IT TAKES NEW AND CREATIVE ROLES

- To complete the work
- To respond to new regulatory changes
- To achieve organizational and departmental outcomes



ROLE #1: PATIENT FLOW – COORDINATION AND FACILITATION OF CARE

- The management of all patient care processes that support a patient as they transition through the continuum of care
- In the acute care setting this would include the coordination and facilitation of tests, treatments, procedures, consults and other care interventions

Shared Between Social Worker and RN Case Manager



PURPOSE OF PATIENT FLOW

- To optimize each day that the patient is in the acute care setting, including evenings and weekends
- Arrange care interventions that the patients requires to occur in proper sequence
- Facilitate the interventions to ensure that they occur in a timely manner and without delay



KEY FUNCTIONS OF PATIENT FLOW

- Assess every patient on admission
- Reassess patients daily
- Lead and/or attend daily interdisciplinary care rounds
- Create a plan of care that outlines the key interventions and outcomes to be achieved each day of the inpatient stay

KEY FUNCTIONS OF PATIENT FLOW (con't)

- Coordinate the key interventions among and between the members of the interdisciplinary care team
- Coordinate as needed with family and family caregiver(s)
- Identify delays in patient care processes and intervene to correct them

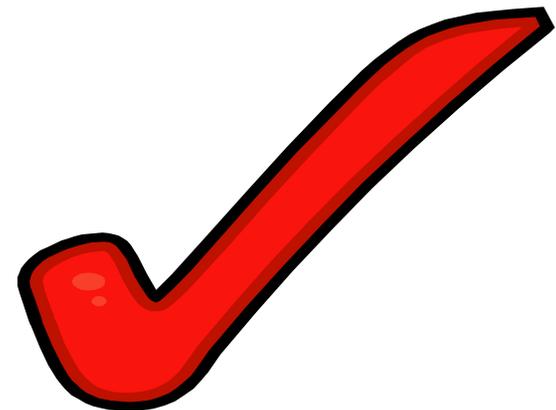
GOALS OF PATIENT FLOW – COORDINATION AND FACILITATION OF CARE

- The plan of care is expedited and barriers to efficient through-put are identified and corrected
- Patient care is provided in a timely manner
- The patient moves smoothly through the continuum of care
- Each hospital day is optimized



PATIENT FLOW IS CRITICAL TO THE ROLE OF CASE MANAGER AND SOCIAL WORKER

- The principle and most important role that the hospital case manager performs
- All other roles stem from this role



ROLE # 2: UTILIZATION AND RESOURCE MANAGEMENT

- Utilization review – first role assumed by hospital case managers
 - Still includes communication with third party payers
- Added resource management - review of resources ordered for the patient to ensure that the appropriate level of care is applied



FUNDAMENTAL COMPONENTS OF UTILIZATION MANAGEMENT

- Review of services to ensure that they are:
 - Medically necessary and reasonable
 - Provided in the most appropriate setting



PATIENT FLOW AND UTILIZATION MANAGEMENT INTERSECT

Utilization Management

- Case manager intervenes when the plan of care does not meet the level of care being provided
- When a correction to patient flow is identified as being needed



RESOURCE MANAGEMENT

- Case managers must ensure that resources are being applied appropriately in the care of the patient
 - Over-utilization
 - Under-utilization
- Resources include pharmaceuticals, radiology services, laboratory services and others.

GOALS OF UTILIZATION AND RESOURCE MANAGEMENT

- Ensure that resources are used appropriately
- Ensure that resources are used in a timely manner and without unnecessary delay
- Ensure reimbursement

ROLE #3: DENIAL MANAGEMENT

Primary Function of RN Case Manager

- The process of monitoring and managing third-party payer reimbursement from pre-admission to post-discharge. Includes:
 - Pre-authorizations
 - Billing
 - Appeals management



KEY FUNCTIONS OF DENIAL MANAGEMENT

- Ensure that the clinical information available in the medical record is accurate and reflects the care rendered to the patient
- Ensure that this information is provided, when necessary, to a third-party payer in a timely manner and based on nationally established guidelines
- Ensure that the patient is transitioned to the next level of care as quickly as possible once the patient no longer meets the clinical criteria for the current level of care

KEY FUNCTIONS OF DENIAL MANAGEMENT

(con't)

- Work closely with pre-certification staff at front-end and billing staff at back-end
- Appeal denials as necessary
 - Internally or
 - Out-sourced

Best defense is a good offense.
Prevent denials whenever possible!

SHARED ROLES

- Pre-Authorization – Finance
- Concurrent Review: Case Management
- Billing – Finance
- Appeals – Case Management and Finance

ROLE #4: VARIANCE TRACKING

- Also known as avoidable delays or avoidable days
- Defined as the causes of delays in patient through-put, care delivery or discharge
- May or may not result in prolonged length of stay
- May result in service delays and quality of care issues



FUNCTIONS WITHIN VARIANCE TRACKING

- Identification of delays in through-put, service delivery or quality of care
- Intervention to correct the delay when possible
- Discussion of delays on patient care rounds
- Catalogue the delays into a database

TYPICAL CATEGORIES

- Internal hospital systems
- Systems outside the hospital
- Patient issues
- Family issues
- Provider issues and delays
- Payer issues

GOALS OF VARIANCE TRACKING

Identification of

- Important single events
- Undesirable variation from established levels
- Patterns or trends that vary undesirably from expected outcomes

ROLE #5: TRANSITIONAL AND DISCHARGE PLANNING

- Focuses on the movement of the patient through the acute care continuum and to the next level of care
- Defined as “a collaborative, interdisciplinary process of assessment, planning, implementation and evaluation of the patient’s healthcare needs following the current phase of illness (Cesta, 2002)



THE ROLE OF THE CASE MANAGER

- Transitional planning is the process the case manager applies to ensure that appropriate resources and services are provided in the most appropriate setting or level of care
- Identification of the point at which the patient can move to the next level
- Coordination of the actual movement of the patient
- Happens within the acute care continuum

DISCHARGE PLANNING

Shared Between RN Case Manager and Social Worker

- Follows the same principles and functions as transitional planning with one exception
- Involves the process of assessing the patient's needs after they leave the acute care setting
- Ensures that the patient's discharge is timely, appropriate and safe, incorporating the best use of resources that the patient may need in the community

ROLE #6: QUALITY MANAGEMENT

ENSURE THAT CARE IS RENDERED
AT OR ABOVE QUALITY STANDARDS



FUNCTIONS OF QUALITY MANAGEMENT

- Identification and documentation of adverse events
- Documentation of readmissions
- Management of progression toward expected outcomes of care

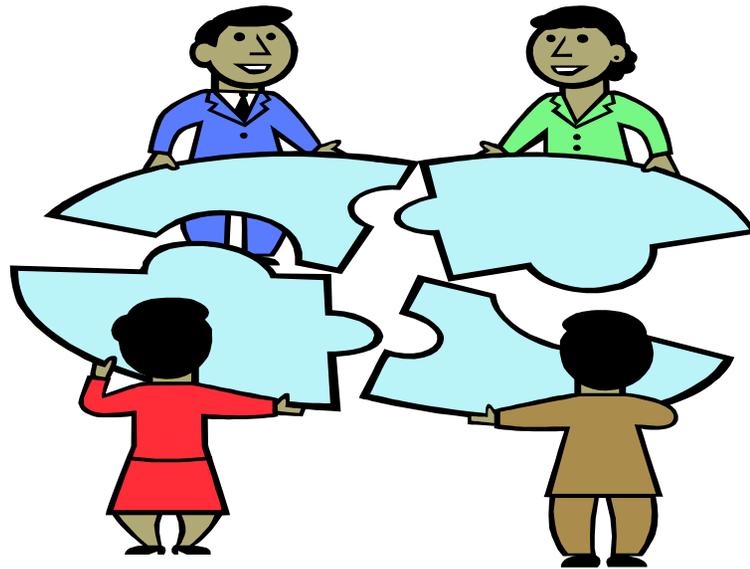
QUALITY MANAGEMENT AND THE CASE MANAGER

- Not all case managers have responsibility for all the functions under quality management
- Even if the CM does not have primary responsibility they can still be a collaborative member in the quality of care process



ROLE #7 PSYCHOSOCIAL ASSESSMENT AND COUNSELING

- Typically performed by the social worker
- Can be performed by the case manager
- May require further intervention from Behavioral Health



PSYCHOSOCIAL INTERVENTIONS

- Important for family members , particularly in the emergency department or critical care areas, burn or trauma units
- Relate directly to discharge planning, patient outcomes, quality of care, and utilization management

PSYCHOSOCIAL INTERVENTIONS (con't)

- Needs to be performed as part of a comprehensive psychosocial assessment
- Included should be:
 - Assessment of the family
 - Significant other
 - Support systems
 - Financial
 - Housing
 - Family/ Family Caregiver

GOALS OF PSYCHOSOCIAL COUNSELING

- Determine the patient's ability to cope with their current phase of illness or chronic condition
- This will impact on the discharge planning process and the ultimate discharge destination

SOCIAL WORK EXPERTISE

- Bio-psycho-social assessments and treatment planning
- Counseling regarding impact of illness and compliance with medical and transitional plans of care
- Crisis intervention regarding abuse and neglect, domestic violence, substance abuse or trauma
- Identifies barriers to affecting a safe and timely discharge plan

THE SOCIAL WORKER IN THE CASE MANAGEMENT MODEL

- Collaborates with the case manager in the discharge planning process, focusing on the most complex patients
- Ensures access to continuing care services

SOCIAL WORK HIGH RISK SCREEN: IDENTIFICATION AND REFERRAL – SHOULD BE MADE AS SOON AFTER ADMISION AS POSSIBLE

- Adjustment to illness or difficulty coping
- Major illness causing lifestyle change
- Behavior management problems
- New or poor prognosis

SOCIAL WORK REFERRALS

- End stage of illness
- Family concerns and / or conflicts
- Cultural and /or language issues
- Inadequate social and / or financial supports

SOCIAL WORK REFERRALS (con't)

- Non-adherence issues
- Ethical concerns
- Abuse and / or neglect of elder, adult, child
- Multi-system trauma

SOME MORE REFERRAL CRITERIA

- Psychiatric and / or substance abuse issues affecting current hospitalization
- Homelessness affecting current hospitalization or request for housing
- Patient / family considering long term care placement, assisted living, or adult home



SOCIAL WORKERS AND NURSE CASE MANAGERS

- Different but complimentary skill sets
- Bring different knowledge to the interdisciplinary care team
- Need to optimize the talents and skill sets of each discipline

IMPLEMENTING THE ROLES OF RN CASE MANAGER AND SOCIAL WORKER

INTEGRATION
IS THE KEY!



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INTEGRATING THE ROLES

1. SIMPLE – NO INTEGRATION

FOCUSED ON ONE CORE ACTIVITY

- Traditional models
- Fragmented
- Expensive
- Potential for over-use or under-use of resources

IN THE BEGINNING – THE TRADITIONAL MODEL

- Fiscal incentives- per diem payments, longer length of stay = more reimbursement
- Social work – a referral based practice based on high risk criteria focused on social dysfunction and life altering medical events with option to case find
- Performed counseling and discharge planning

IN THE BEGINNING – THE TRADITIONAL MODEL

- Utilization review – does the patient need to be hospitalized?
- Is the patient medically ready for discharge?
- Give the HINN
- Discharge = What's the rush???????

INTEGRATING THE ROLES

2. MODERATE – PARTIAL INTEGRATION FOCUSED ON TWO OF THE CORE ROLES

- Contemporary model design
- More efficient
- More cost-effective

A FIRST STEP – PARTIAL INTEGRATION

- Fiscal incentive – move to DRGs and fixed payment per admission
- Social work – aggressive screening, initiation and coordination of early discharge planning
- Psychosocial counseling if time permitted

A FIRST STEP – PARTIAL INTEGRATION

- Utilization review evolved into case management
- Utilization review added heavier emphasis on meeting continued stay criteria and managing the medical needs of the patient
- Identify barriers to discharge and anticipate discharge needs
- Discharge sooner rather than later and spend less money on the case

INTEGRATING THE ROLES

3. COMPLEX – FULL INTEGRATION FOCUSED ON ALL CORE ROLES

- Forward thinking
- Most efficient
- Most cost effective
- Must be balanced with appropriate case loads

MEETING THE CHALLENGE – FULL INTEGRATION

- Fiscal incentives including managed care
- Authorization for discharge planning
- Continued stay denials
- Recovery Audit Contractors (RAC)
- Financial penalties for readmissions

MEETING THE CHALLENGE – FULL INTEGRATION

- Advances in medical technology
- Shorter lengths of stay
- Greater use of high tech home care
- Palliative care
- Hospice care

MEETING THE CHALLENGE – FULL INTEGRATION

- The paradigm shift for case managers and social workers:
 - Managing care becomes priority in order to manage length of stay
 - Assess patients for post-acute care needs
 - Case manager's begin managing clinically related discharge planning needs
 - Social workers have greater focus on life altering illnesses, trauma, social and family dysfunction and end of life issues

A LOOK AT INTEGRATION – SHARING DISCHARGE PLANNING



WITHIN THE DEPARTMENT OF CASE MANAGEMENT

- Need specialized roles
- Clear demarcation of who does what
- Optimize existing resources

GOALS OF ACCESS POINT CASE MANAGEMENT

- Manage and control the types of patients approved for admission
- Provide for alternative care when needed and appropriate
- Ensure hospital reimbursement

ADMITTING DEPARTMENT CASE MANAGEMENT

Provides Gatekeeping Function For

- Planned admissions
- Urgent admissions
- Direct admissions
- Transfers

EMERGENCY DEPARTMENT CASE MANAGER ROLE FUNCTIONS

- Gatekeeping
- Coordination/facilitation of care
- Utilization/resource management
- Transitional planning



PERI-OPERATIVE CASE MANAGER

- Responsible for patient from pre-admission testing until the PACU
- Provides clinical coordination and transitional planning across the continuum of the patient's surgical stay.
- Identifies and removes barriers to moving patients through the hospital system including barriers identified during pre operative preparation.
- Coordinates discharge from PACU with the physicians, nurses, patients and families.
- Makes direct referrals to home health, sub-acute or acute rehab as needed, and provides pertinent information.

TRANSFER CENTER CASE MANAGER

TRANSFERS IN

- Reviews medical necessity, both level of care and status for any patient transferred in to any of the following that are owned by the hospital
 - IP hospital
 - IP Rehab
 - LTAC
 - SNF
- Has working knowledge of EMTALA rules and regulations so patients transferred from outlying hospital EDs are handled appropriately

TRANSFER CENTER CASE MANAGER (con't)

- Serves as liaison between sending hospitals and case managers on units (accepting hospital) for communication regarding medical necessity and any communication between transfer center case manager and accepting physician
- Assures authorization for any patient transferred in who is out of network (unless EMTALA applies)
- Participates in timely acceptance of patients transferred in
- Works with Patient Access to identify any non-EMTALA patient transferred in to assure accurate assessment of benefits
- When time allows, reviews any documents from sending hospitals (I'd like to see transfer centers allow uploading of the patient record so the transfer center case manager can review this and do the initial review of medical necessity while the patient is being transferred in)

TRANSFER CENTER CASE MANAGER (con't)

- For any patient that is on the waiting list to transfer in, reviews documents to assess medical necessity and any potential discharge planning

TRANSFERS OUT

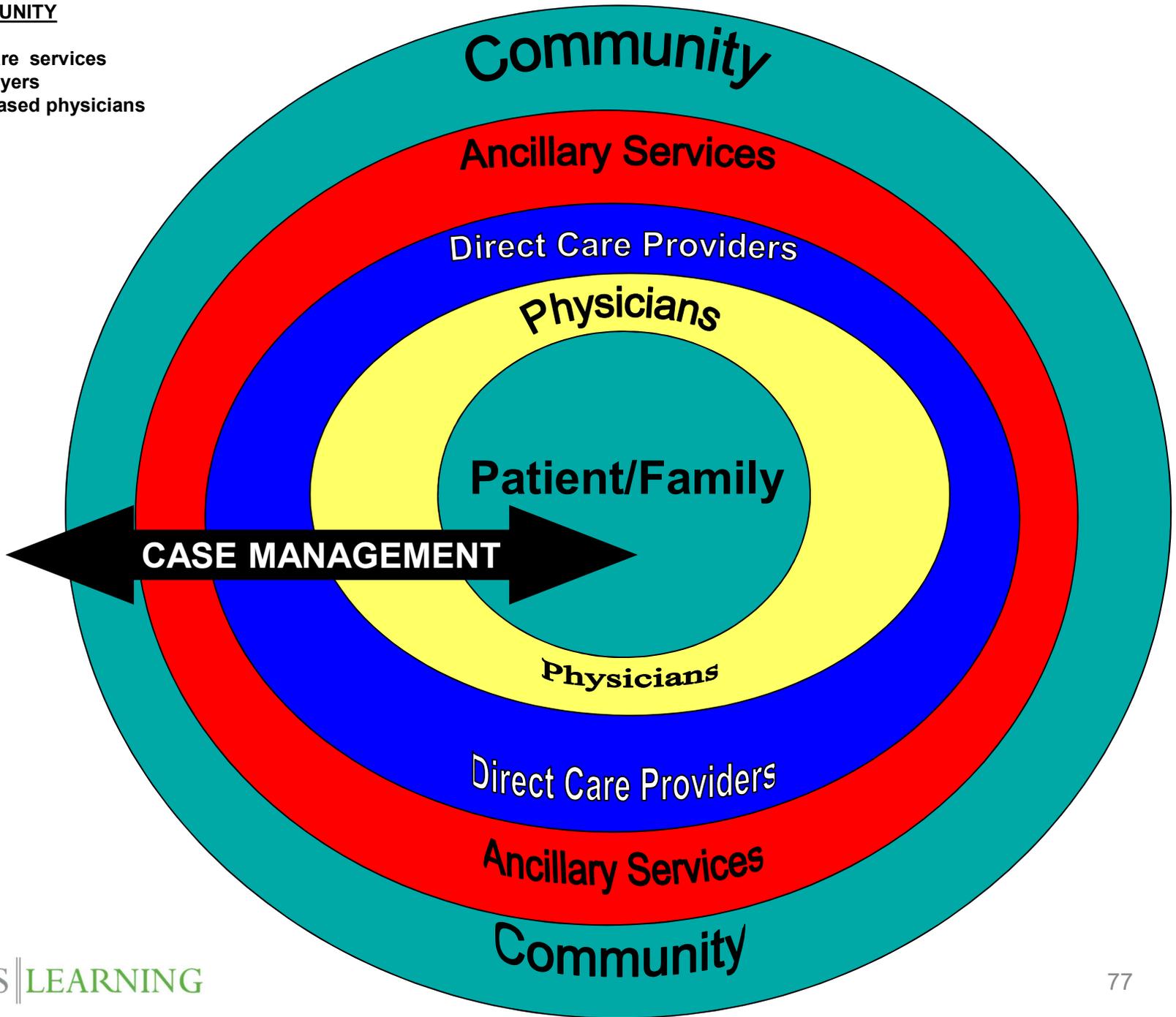
- Coordinates applicable EMTALA rules and regulations
- Reviews required state forms for appropriate completion on transferred patients (Toni, Texas has fined hospitals for not having these forms filled out right)
- Assures authorizations for any payer requiring this (usually for either higher level of care or services not provided in hospital)
- Participates in any collegial discussions with facilities transferring to system facilities

COMPLEX DISCHARGE PLANNING SPECIALIST

- Focuses on the most complex, time-consuming discharge plans
- Selects patients from those exceeding the hospital's self-selected long stay threshold.
- Manages these patients in conjunction with the RN case manager.
- Interfaces with other departments and community agencies as appropriate
 - Legal
 - Police
 - Community liaisons

COMMUNITY

- Health clinics
- Continuing care services
- Third party payers
- Community-based physicians



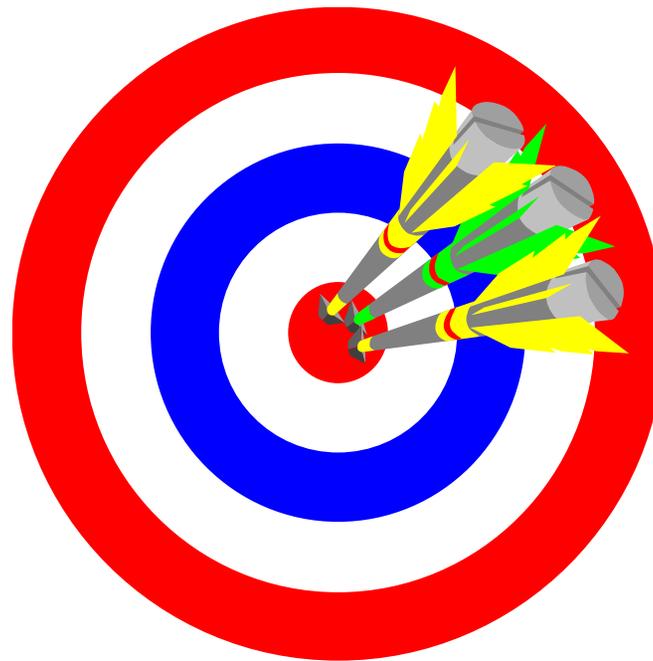
ULTIMATE GOAL

Right service

Right time

Right cost

Right place



RESOURCES

- Cesta & Tahan (2017) The Case Manager's Survival Guide: Winning Strategies in the New Healthcare Environment, 3rd Ed. Lancaster, DesTech.
- Cesta & Cunningham (2009) Core Skills for Hospital Case Managers. Marblehead, HCPro.
- Treiger & Fink-Sammick. (2016) Collaborate for Professional Case Management. New York, Wolters Kluwer.

IT'S TIME FOR QUESTIONS

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THANK YOU