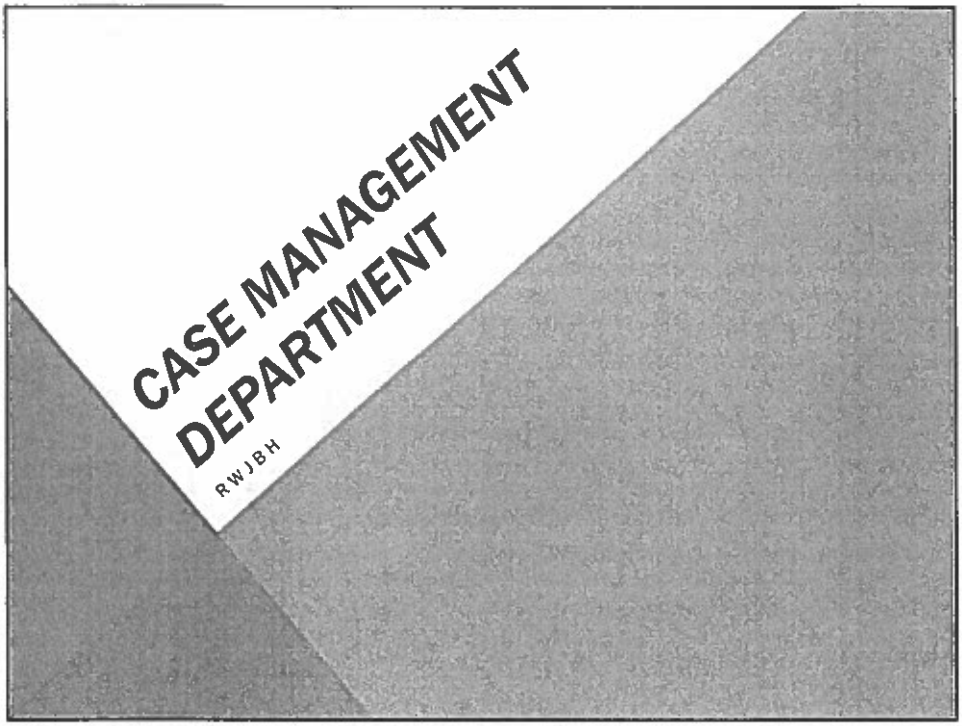

CASE MANAGEMENT DEPARTMENT

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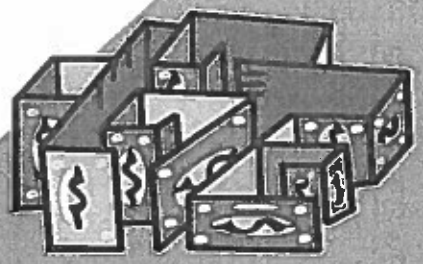
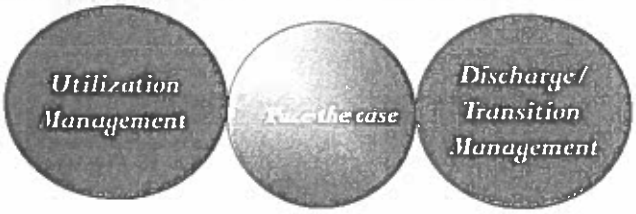
CARE COORDINATION... THE FOUNDATION OF PATIENT CARE MANAGEMENT



What Care Coordination is and why it is important.

CARE COORDINATION: THE MISSING LINK



- **Care Coordination:**
  - Attention to and management of the elements and sequencing of care to achieve targeted outcome(s)
  - *Historically, "discharge" was the outcome. Best practice currently, outcome is the reasonable state of stability to transition patients to further recover and sustain their wellness in the community using treatments, education, and information afforded the patient by the provider.*
- **Best achieved:**
  - When there is a focus on coordination of care as a standard process, and always using a **multi-disciplinary model.**

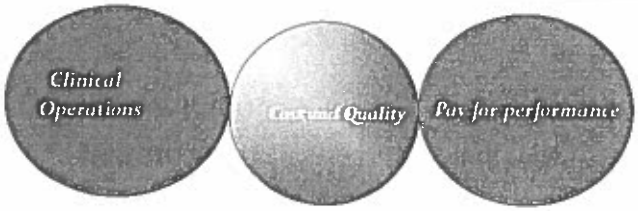
Begins prior to entry to the "building":

- scheduling, testing, ED/ RDU, Triage, Direct Admissions, etc...

And continues through Transitions in Care follow-up in the Community

KATES, S., RWJBH CMC

CARE COORDINATION: CASE MANAGEMENT TRANSECTS ALL DOMAINS



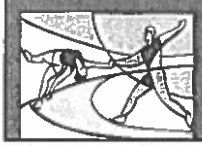
- **Clinical Operations:**
  - Case Management, Bed Management, Capacity Management Surveillance, Operational Delay prevention, Productivity, Logistics, effective use of portals (ED, RDU, Hospice, Cath lab,)
- **Cost and Quality:**
  - Care Coordination using multidisciplinary model, CDIP and DRG Maximization, Clinical effectiveness, Utilization management, Discharge Planning, Post acute preferred network
- **Pay for Performance:**
  - Transitions in Care, Readmissionprevention, Bundles, Patient Satisfaction, Employee engagement andcommunityreferrals

THE CORE OF PATIENT CARE MANAGEMENT: NURSES AND SOCIAL WORKERS IN CASE MANAGEMENT

Each brings unique skills and knowledge to the patient care management arena.

- Clinical Nurses trained in disease trajectory, pathophysiology, and psychopharmacology
- Master prepared social workers trained in psychosocial support in strength based manner, crises management, and managing social determinants of health with resources

The best systems synergistically maximize the use of the skills, knowledge, and talents of both disciplines.



VULNERABLE PATIENTS AND CARE COORDINATION

•All patients need their care coordinated. Some patients (and populations) are particularly vulnerable to less than desired state

•These patients require more intense coordination from Case Managers and Social Workers. Department uses many tools to identify these patients: MD Consults, evidence based Utilization criteria, twice daily unit rounds, LACE index, readmission list, community referral, and more.

•The focus is:

- Clinical outcomes
- Satisfaction
- Length of stay
- Cost reduction
- Risk for readmission reduction

PRIORITY PATIENTS FOR CASE MANAGEMENT INTERVENTION

- Vulnerable children and adults.
- Newly diagnosed with chronic or life threatening illnesses.
- Economic burdens created by illness, including payer limits.
- Patients experiencing chemical dependency or abuse.
- Patients who need to transition within the health care community.
- Patients with high technology needs in the community
- Readmissions
- Chronic health populations
- Social determinants of health impacting patients' ability to be well- resourced or to cope

CASE MANAGERS AND PHYSICIANS

Chronic communication regarding assessment of where is the patient along the clinical care trajectory.

- Is the patient at the right place at the right time?
  - Status orders for LOC
- Is care consistent with the clinical picture?
  - Limited use of consultants not immediately connected to reason for admission
  - Not applying interventions or tests that are outpatient level of care.
  - Holding testing departments and consultants accountable for timely intervention
  - Documentation that reflects MDs concerns and assessments
- What is the anticipated next level of care decision-making?
- Plan for patient/family self-management/ transition to alternative setting in the community

CASE MANAGERS AND PHYSICIANS: UTILIZATION MANAGEMENT

Utilization And Resource Management:

- Evidence based review: Completed on daily basis on all payers to match LOC/plan of care/documentation/regulatory compliance
  - Utilization Committee mandated by CMS
- Status: *Inpatient* (CMS 2 midnight rule) versus *Observation* (24hour and with extensive documentation if exceeds)
- Physician Advisor : internal and external roles
- Physician compliance and communications with Case Managers
- Regulatory: ABN HINN

CASE MANAGERS AND PHYSICIANS: CLINICAL COLLABORATION AND PACING THE CASE

The most intense, focused periods in patient care management generally occur around admission and discharge.

This can divert attention from:

- The middle of the case.
- Pacing the case.

LOS and Quality impact: Evidence shows LOS delays/ denials/ avoidable days for delays in care occur in middle of case.

Case Managers are LOS and LOC experts.

SOCIAL WORK AND PHYSICIANS: A CRITICAL PARTNERSHIP

Key Functions: Assessment

- Crisis Intervention
- Family meetings
- Life planning (also called "Plan for the Way")
- Referrals for Community Services and rehab settings Support groups
- Social and Ethically complex cases
- Documentation expectations:
  - Basic demographics
  - Reason for admission
  - Psychosocial strengths and weaknesses
  - Family/friends support
  - Identified spokesperson
  - Plans for intervention

METRICS

- **Performance and Operational metrics that engage and benefit MDs:**
  - Avoidable days report– supports MDs when resources or services not available
  - Weekly ED throughput (by hour)
  - Daily tracking of delays in MDs responding to consults within 24 hours (by MD)
  - Daily tracking of Observation pts exceeding 24 hours (by volume)
  - Utilization Review of Denials (by $, MD and by cause and payer)
  - Monthly tracking of MDs not responsive to external Physician Advisor outreach
  - Daily tracking of d/c orders entered before noon and actual d/c within 2 hours of order (by volume, and percentage)
  - Weekend: Volumes of discharges, delays in MD orders for PT, delays in radiology tests ordered by MD

PHYSICIAN ADVISOR AND MD PARTNERSHIP

- Role of Physician Advisor
  - Clinical review process
  - Regulatory Compliance
- Examples of communication goals:
  - Level of Care (LOC)
  - Length of Stay (LOS)
  - Outpatient testing versus inpatient
  - Status orders
  - Denial risk

PERSON -CENTERED APPROACH: WHAT DO FAMILIES WANT?

- The physician to tell me everything
- Mom to be just as good as she was before she came to the hospital
- I have a life - I can't change it for Mom
- The physician needs to be available when I am
- I need a professional to help me get what I need to manage… and it cannot be on the last day of mom's stay
- Food, fuel, clean water, shelter

Dr. Richard Cabot, The Doctor and The Social Worker, 1905

WHAT DO FAMILIES WANT? HELP ME, DON'T HURT ME, BE KIND TO ME.

(DR JOHN BONAMO, RWJBH, 11/8/2016)