How to Build a Case Management System that Leads to Success

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OBJECTIVES

- Identify, define and develop a case management system to meet individual patient needs and increase patient outcomes
- Understand the importance of completing an accurate comprehensive patient assessment in a standardized manner throughout the agency’s entire interdisciplinary team.

OBJECTIVES

- Realize the importance of delivering GOAL DRIVEN CARE vs TASK ORIENTED CARE
- Acknowledge that On-Going Communication between the team is of utmost importance and that all communication must be documented
- Understand that it is the responsibility of the team to not only acknowledge problems, but to follow up and resolve all patient problems.
Introduction

- Effective case management is dependent upon the interdisciplinary team working together towards collaborative goals and coordinating the patient care in a PROACTIVE MANNER.
- The primary goal of the home care clinician is to enhance patient outcomes by planning a course of interventions and developing a plan to achieve the goal.
- The case manager takes this a step further by coordinating the patient care with the other nursing staff and healthcare professionals to ensure a collaborative team approach.

Steps to Case-Management

- Case Management begins with the referral.
- Discharge instructions and/or specific orders from the hospital and physician must flow to the Plan of Care for an continuum of care to be effective.
- The physician orders on the discharge instructions are what begins the patient’s plan of care. Be sure they correlate with orders on the 485.

Planning the Care

- **Pre-Admission Conference**
  - Admission Nurse with Intake RN
  - Discuss referral information
  - Identify expected diagnoses
  - Which services will be needed.
STEPS TO CASE-MANAGEMENT

Admission Visit
- Explain the primary goal of your services.
- Discuss an anticipated discharge date; discharge planning must be introduced on the first visit.
- During assessment, evaluate what other disciplines are required in order to meet the needs and goals of the patient.

COMPREHENSIVE ASSESSMENT

Admission Visit
- Perform a comprehensive assessment of the patient.
- Do not simply ask the patient questions when doing the comprehensive assessment.
- Ask the patient to walk you to the bathroom to show you the set up or to the kitchen for a drink of water; have the patient read you his medication bottles.

In doing this, the clinician will be able to answer the questions on the assessment in the most accurate fashion.

All disciplines on subsequent evaluations and visits need to perform the same type of assessment in order to be objective and assure accuracy of the patient outcomes.
Admission Visit
- Establish preliminary goals for THE EPISODE of care and for discharge on the admission visit
- The clinician and patient/caregiver must agree on goals or success cannot be achieved
- The goals must be realistic, objective and achievable

Identify other disciplines or resources to assist the patient/caregiver in achieving the goals.
- These disciplines need to be involved in the development of the Plan of Care (485)
STEPS TO CASE-MANAGEMENT

ADMISSION CONFERENCE

- This initiation of coordination of care upon admission will lead to goal directed care.
- Without this, each discipline is often working towards his/her own independent goals.

GOALS

RN MSW PT, OT, ST

THE PLAN OF CARE and PROJECTING THE EPISODE

- Interdisciplinary communication takes place after each discipline assesses the patient.
- Goal is to have input prior to printing of 485 in order to have discipline frequency, duration and orders.
- If other disciplines see patient within 48-72 hours, this can be possible.
THE PLAN OF CARE and PROJECTING THE EPISODE

For GOAL DRIVEN CARE this is essential!

Front Load Visits - Plan increased frequency for all disciplines at beginning of care, then decrease on plan as episode progresses and patient works towards the goals set by the team.

THE PLAN OF CARE and PROJECTING THE EPISODE

CLINICAL NEEDS ARE ALWAYS FIRST PRIORITY — BUT
DON'T FORGET THAT WITH THE PPS SYSTEM, FINANCIAL PLANNING IS THE SECONDARY CONSIDERATION
PROJECTING THE VISITS ALLOWS ASSESSMENT OF THE FINANCIAL OUTCOME FOR THE EPISODE - DON'T BE SURPRISED — TRACK THIS INFO AS YOU PROGRESS

THE PLAN OF CARE and PROJECTING THE EPISODE

Utilization of Disciplines

Be sure that you are not under utilizing services thinking that you must do so to survive financially

If your patients are case managed, often more disciplines can decrease SN visits, length of stay AND increase outcomes
THE PLAN OF CARE and PROJECTING THE EPISODE

**MSW’s**
- An MSW visit can increase SN productivity and decrease visits
- Be Sure that the MSW documents their skilled need
- Be Sure that the MSW Follows UP by making a second visit when necessary for resolution

**OT’s**
- Especially if ADL and IADL scores are low
- If Aide Services are ordered
- OT can assist Aide in progressing the patient’s independence leading to a decreasing of Aide visits over the episode
- For pts with compromised respiratory systems, OTs can work on energy conservation techniques

**COMMUNICATION, COMMUNICATION, COMMUNICATION………..**
- Frequency
  - Formal Case Conference may not be frequent enough; Don’t Save Up Problems
  - Keep communication brief, concise, to the point
  - Weekly is recommended and of course when ANY pertinent changes
Identify what should be communicated. This is important to avoid lengthy, detailed communication.

Coordination of care communication needs to be very pertinent information between the entire team.

Identify when the communication should take place. It can be informal or formal, weekly or bi-monthly.

All must be documented in the medical record.

Sub-contracted Therapists
- Not an excuse for poor and infrequent communication and coordination of care
- Hold your Sub-Contractors Accountable
- They must interact with the team on all patients as if they were your employee.

Evaluate how the plan is working

The patient's progress needs to be regularly assessed and discussed as a team.
- This way the team will be "on the same page"
- The team may decide that another discipline is needed in order for the patient to meet the goals
- Or the goals and the plan of care may need revision, be sure to include the physician & receive orders.
Get to the Root of the Problem

- Homecare clinicians are typically very good at identifying patient problems, however, often the problem is not fully addressed in an appropriate manner.
- By working as a team, getting to the Root of the Problem is much easier.
- By communicating regularly as a team, solutions to problems, revision of goals, physicians input and orders, and an increased family involvement often occur increasing patient outcomes.
- Document your follow up and resolution!

Discharge or Recertification?

- A formal agency case conference is advised to be held on a monthly basis per patient to plan the upcoming month.
- Patients with ending episodes approaching in 2-3 weeks should be discussed as a team and a decision made to discontinue care, discharge from a discipline, or recertify.
- Always case conference before a discipline discharges, formally or informally.

Discharge or Recertification?

- Whether to discharge or to recertify is not an easy decision in many cases, and the decision should not be made by one person; this needs to be the team's decision in order to assure that goal driven care is provided.
- While discussing the need to discharge or recertify, it may become clear that one discipline should discharge, while another needs to recertify.
Discharge

When discharging the patient, again, assure that the assessment is done in a thorough and objective manner, using the same approaches at admission and throughout care.

The results of your patient’s outcomes and of your agency’s outcome measurements (OBQI) depend on this consistency.

Recertification

Assure that continuing communication occurs between those team members still seeing the patient.

Do the goals need revision? Often, when patients are recertified, this is a key element that is necessary, but often overlooked.

Be sure that your Plan of Care (483) for this episode does not mirror your one from the last episode. And if utilizing Care plans, be sure that they are revised appropriately by the team.

Scheduling in an Effective Case Management System

Empower your Clinicians to Manage Their Patients

Assign Patients to Clinicians

They carry a Caseload

They submit their weekly schedules to mgmt
Scheduling in an Effective Case Management System

- Management Provides Oversight of Schedules
- Reconcile to Master Schedule
- Verify Patients are seen and visits are done per physician’s orders
  - By Logs
  - By Voicemail
  - By Audits

Scheduling in an Effective Case Management System

- Identify those RNs appropriate and willing to be Case Managers
- Form Teams consisting of Case Manager and Visit Nurses (RNs and LPNs)
- Have All disciplines on a Case Management Team
  - Some disciplines have to cross over teams as volumes are low - Ai, ST, MSW

STEPS TO CASE-MANAGEMENT

- Look at the BIG PICTURE
- You are caring for the patient, not the wound
  - You are coordinating care and collaborating with multi-disciplines of healthcare professionals, not acting alone
  - You are working with a patient in his home environment, with his family or caregivers interacting in a dynamic fashion
**STEPS TO CASE-MANAGEMENT**

- Be **ACTIVE**, not **Passive**
  - You and the other clinicians are identifying issues and concerns relating to your patient’s well-being. Address every one of these issues!!!!

- Your Team Must be responsible to follow through with problem-solving for your patient….they are depending on you!

**STEPS TO CASE-MANAGEMENT**

- Remember…Although Homecare Clinicians do task oriented procedures, we are primarily with the patient to **ASSESS AND TEACH**!

- **GOAL Driven Care** by a Multi-disciplinary Team is the Key to enhancing patient outcomes!

**EFFECTIVE CASE-MANAGEMENT & CARE COORDINATION**

- **KEY TO SUCCESS**
  - Increased Patient and Agency Outcomes
  - Increased Financial Viability
  - Increased Customer and Employee Satisfaction