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What It Takes To Be
The Best Case Manager

Overview

- Identify Case Manager Role and Responsibilities
- Identify Differences Between Good Case Manager and Great Case Manager
- Identify How to Appropriately Schedule and Delegate Visits
- Identify Tips for Time Management

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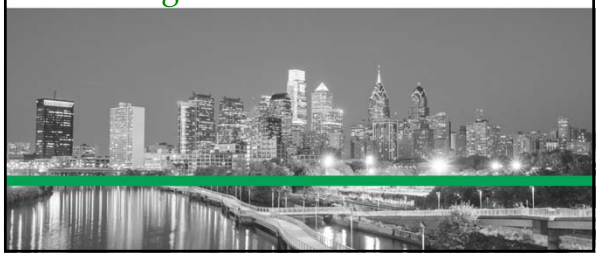
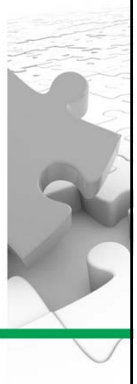
Case Management Role



What Makes a Good Case Manager

A good case manager has the following skills:

- Assessment Skills
- Teaching Process
- Broad Spectrum of Nursing/Therapy Treatment Skills
- Understands Reimbursement Complexities
- Understands the Referral Process
- Interview Skills
- Develop Strong Plan of Care
- Sets Realistic Goals
- Verbal Orders Are Entered In EMR At Time Of Receipt



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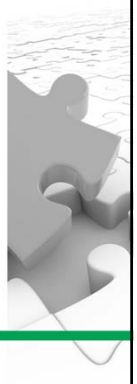
What Makes a Great Case Manager

A great case manager has these additional skills:

- Strong Communication Skills
- Able to Delegate and Supervise
- Able to Troubleshoot Issues
- Great Documentation Skills
- Time Management System
- Understands Episodic Management
- Understands Conditions of Participation
- Monitors Outcome Improvement
- **KNOWS WHEN TO ASK FOR HELP**



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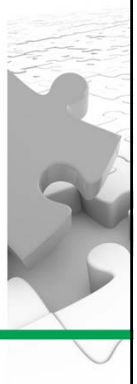
Case Management

- Every patient has one
  - Home Health:
    - Multiple discipline case (SN is case manager)
    - Multiple therapy disciplines (PT is case manager)
  - Hospice:
    - Nursing is always the case manager
- Every patient should know who is on the team
  - Home Health:
    - Required to list clinical manager with contact information
    - Visit schedule must be in writing in patient home



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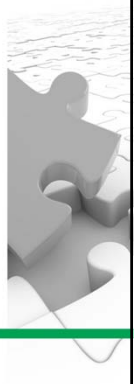
Other Case Management Duties

Follow Up

- Plan for Next Visit/Report to Staff
- Labs
- Medication Changes
- Physician Orders
- Caregiver Communication
- Transfer Coordination
- Authorizations
- Chart Reviews



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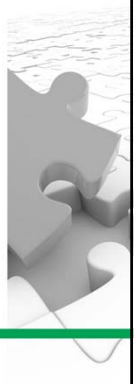
Case Management

Patient advocate from Admission to Discharge

- Assessment Needs
- Coordinating Care (agency and community)
- Addressing Delays in Care
- Addressing Delay in Progress
- Coordinating Discipline Care
- Coordinating Physician and Payer Updates
- Coordinating Insurance Authorizations
- Discharge Planning



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Care Coordination

Teams Concept: Home Health

Assess for needs and utilize your team

- PT Eval if:
  - HHRG F2 or F3
  - MACH 10 is >4
  - TUG > 13 seconds
  - History of falls or recent hospitalization related to falls
- OT Eval if:
  - COPD or Pneumonia
  - Energy Conservation (CHF/COPD)
  - Bathing score >3
  - Low vision Issues
  - Barthal index score less than 60

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Team Concept: Home Health

- ST Eval if:
  - Dementia
  - Swallowing
  - Cognitive deficits
- Home Health Aide if:
  - Incontinent
  - Wounds
  - High risk falls
  - No caregiver as a safety risk
  - Barthal index score below 60

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Team Concept: Home Health

- Social Worker Eval if:
  - No insurance
  - Unable to afford medications
  - Advance Directives
  - Complicated caregiver
  - Poor living conditions
  - Long term placement options
  - Psychosocial concerns
  - Needs for home adaptations
  - Evacuation planning

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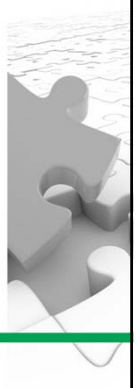
Care Coordination: Home Health Team

- Collaborative Communication With all Team Members Minimum Every 2 Weeks
  - Documentation in EMR collaboration on:
    - Progress to goals
    - Issue to reach goals
    - HEP in home and reinforced
    - Medication compliance/issues
    - Falls or other complications
    - Plan for discharge/recertification



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Care Coordination: Home Health Team

- Document Notification of Any Changes in Patient Condition to All Disciplines and MD
- Document Coordination Between SN and LPN/RN Follow Up
- Wound Assessment Each Visit
  - Wound measurements every week unless agency policy indicates differently
- Document Coordination Between PT/PTA

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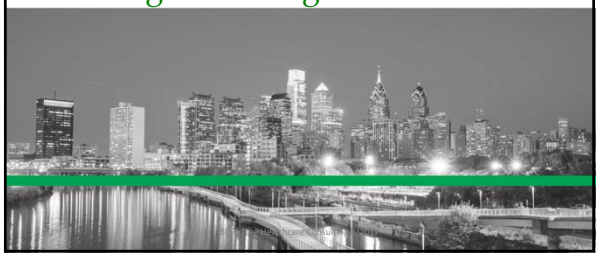
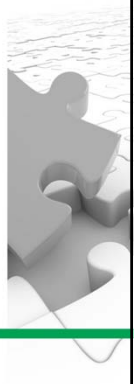
Scheduling and Delegation



Scheduling Considerations

- Admission
  - Introduction of team
  - Continuity of care
- Home Health Follow Up Assignments
  - Days since Case Manager last visit
  - Stable patient
  - HHA supervisory visit every 14 days
  - LPN supervisory visit every 30 days
  - Days to recertification/discharge
  - Front Loading



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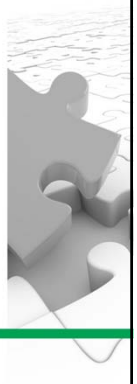
Delegating Visits

- Things to Consider:
  - Has there been multiple changes in POC
- Best Patients to Delegate to Team
  - Wound care patients >2 times per week
  - Infusion patients > 2 times per week
  - Chronic disease stable patients
  - Orthopedic patients
- Worse Patients to Delegate to Team
  - Monthly foley or B12
  - Frequent hospital or ER utilization
  - Complicated psychosocial/family
  - Actively dying
  - Difficult symptom management



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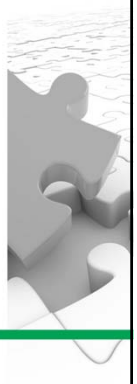
Team Member Communication

- Review Patient Record Prior to Visit
  - Review 485
  - Plan for next visit
  - Validate questions prior to visit
- Follow Up
  - If you identify changes or issues:
    - YOU should call the doctor and write verbal order
    - If MD does not respond YOU need to report off to case manager
    - YOU need to follow up with patient with changes
- Document Coordination With Case Manager



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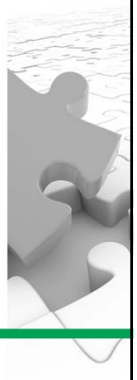
Team Member Communication

- Follow Up
  - If you draw labs YOU need to get results and notify doctor
  - YOU should order additional supplies if needed
  - You are responsible for all the documentation
  - You should give report to case manager after visit
  - If you meet someone else in home (therapist) YOU can do case conference



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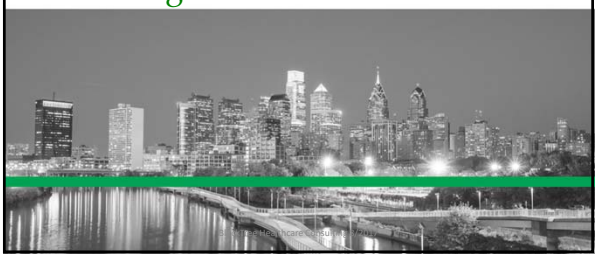
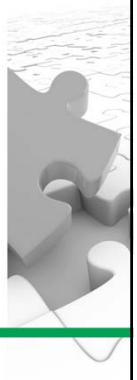
Time Management



Time Management for Work Day

- Know Your Visit
  - How long does visit usually last
  - What do I have to do at visit
    - Timing constraints – labs, infusion
  - How much travel time to and from visit
  - Is this an OASIS visit
  - No more than 2 OASIS visits if possible
  - Does the family/caregiver need to be there



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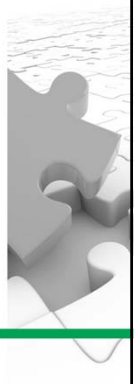
Time Management for Work Day

- Control Your Visit
  - Plan for next visit at the last visit
  - Use calendar in home to see other visits scheduled
  - Call patient night before and set time
  - Review prior visits
  - Document in the home
  - Call the doctor while in the home
  - Have all supplies with you
    - Medical Supplies
    - Education
  - Reorder medications while in the home
  - Call MD while in the home



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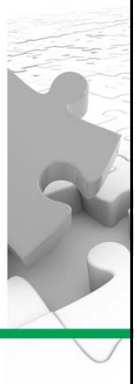
Time Management

- Control Your Calendar
  - Schedule visits by location
  - Delegate visits
  - Keep a list of patients with important due dates
    - Date of next supervisory visit
    - Due date case conferencing
    - Catheter change due date
    - Discharge /Recertification Date
    - MD appointments
  - Keep meetings on calendar



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Case Management Weekly Roster

Patient Name	Phone #	HHA Sup Visit Due	Weekly Visit Schedule								
			Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Therapy	End Cert Date

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Time Management

- Office Time
  - Limit time in office
  - Find other locations to work
  - Document in the home
  - Coordinate visits around scheduled meetings
  - Consider remote meetings

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Time Management

- Telephone Time
  - Keep list of frequent numbers
  - Put MD numbers on assignment sheets
  - Keep team members number handy
  - Keep list of items for supervisor and cover in one call
  - Follow up on all labs at one time
  - Find the best time to reach MD when you are most likely to reach him
  - Triage when it is ok to leave message versus talking to MD
  - Consider sending fax

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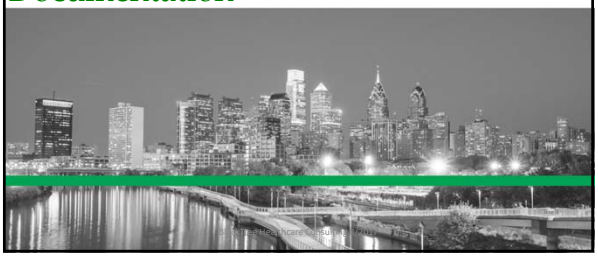
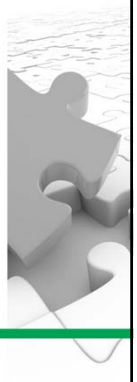
Revisions To Home Health CoP Impacti Documentation



Assessment Changes

- Psychosocial and Cognitive Assessment
  - If patient has deficits need to do additional assessment beyond OASIS
- Identify Patient's Strength, Goals and Care Preferences That Are Then Used in Goal Setting
- Identify Patient Representative(s)
- Assess Patient's Primary Caregiver and Other Available Support
  - Willingness and ability to provide care
  - Availability and schedule



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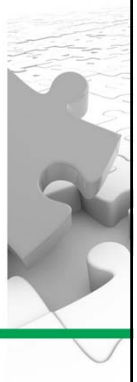
Plan of Care

- Individualized Plan of Care Must Include Patient and Caregiver Education/Training Specific to Patient's Care Needs
- Assess for Risk for Rehospitalization and ED Usage
- Develop Interventions to Address Underlying Risk Factors
- Pt/Cg Education and Training to Facilitate Timely Discharge
- Goals Identified and Created With The Patient Input
- Revisions to Plan of Care Must Be Communicated to Patient, Representative, Caregiver and MD



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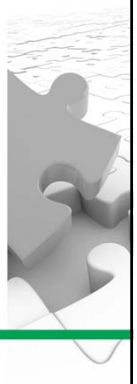
Documentation

- Verbal Orders MUST Include Documentation of Date and Time Order Received
- Written Instructions Must be Provided
  - Visit schedule
  - Medication
  - Treatments
  - Name and contact info Clinical Manager
- All Interventions on Plan of Care/485 Must Be Addressed
- Infection Control Education Must be Provided to All Patients and Caregivers



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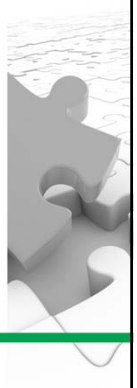
Plan of Care

- Physician Signing 485/POC Must be Updated On All Verbal Orders Received
- All Physicians Involved in Plan of Care Needs Communication and Coordination of Care
- Discharge Plan Must be Communicated to Pt, Representative, Home Health Physician and Other Health Care Professionals Providing Care Post Discharge
- Discharge Summaries Must be Written and Sent to Community Practitioner Within 5 days



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Questions?

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