How to Build a Case Management System that Leads to Success

PRESENTED BY

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PROFESSIONAL HOME HEALTH CARE

OBJECTIVES

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

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 clinicians caring for the patient to ensure a collaborative team approach.

CASE MANAGEMENT BEGINS WITH THE REFERRAL

- Discharge orders from the hospital & physician must *flow to the Plan of Care* for a continuum of care to be effective
- Be sure orders correlate with orders on the 485
- Begin planning the episode with assignment of disciplines ordered to the patient- THIS IS THE CASE MANAGEMENT TEAM!

ADMISSION VISIT

- Explain the *primary goal* of your services
- Discuss an anticipated discharge date; It is Not the 60 day episode.
- 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-OASIS

- 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 how he does his toileting and hygiene
  - walk you to kitchen for a drink of water and snack
  - read you his medication bottles to you
  - take his socks & shoes off for assessment and then put on again

COMPREHENSIVE ASSESSMENT-OASIS

- By having the patient show you , 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.
- Often the variances in the assessments for OASIS timepoints are due to clinicians performing differently.

INVOLVING THE PATIENT AND CAREGIVER/FAMILY IN THE HOMECARE PLAN OF CARE

- Establish preliminary goals for the episode of care With the patient and caregiver 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

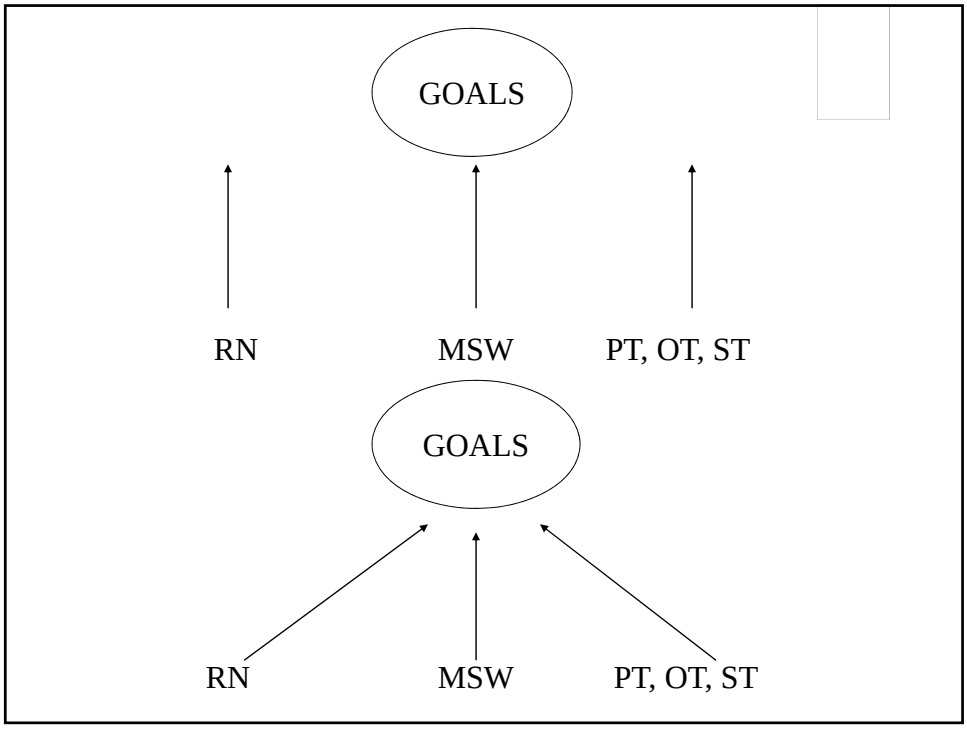
ADMISSION CONFERENCE

- Admission nurse, all members of the team and the clinical coordinator will conference ***Briefly*** after the admission visit is made.
- Issues identified during the assessment will be discussed
- Keeps other clinicians from "going in blind"
- This Interdisciplinary Team will develop a proposed plan based on the input of the Admission RN, discussing diagnoses and projected frequency and duration

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.



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*
- *This keeps the POC/485 from being just a Nursing plan*
- For GOAL DRIVEN CARE this is essential!

THE PLAN OF CARE AND PROJECTING THE EPISODE

- The team projects number of visits per week and schedules as a team
  - This prevents 3 visits a day to patient
  - Be each other's eyes and ears- report issues to each other
- 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

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 utilizing more disciplines can:
  - Decrease SN visits
  - Decrease length of stay
  - Increase outcomes
  - May increase reimbursement

UTILIZATION OF DISCIPLINES – MSW

- Specialty many HHA's do not utilize!
- An MSW visit can increase SN productivity and decrease visits and office time
- 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

UTILIZATION OF DISCIPLINES – OT

- Agency's secret weapon if ADL and IADL scores are low to increase outcomes
- When 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, OT's can work on energy conservation techniques

OUTCOMES

- After all initial assessments by the disciplines, “meet” to choose outcomes that will be focus of episode
- Many are related to All disciplines:
  - Pain
  - Ambulation
  - Dyspnea
- Team formulates plan to increase these patient outcomes working together!

COMMUNICATION, COMMUNICATION, COMMUNICATION……

FREQUENCY

- Formal Case Conference may not be frequent enough; Don’t Save Up Problems
- Team needs frequent communication
- Keep communication brief, concise, to the point
- Weekly is recommended and when ANY pertinent changes

COMMUNICATION, COMMUNICATION, COMMUNICATION……

- Identify what should be communicated. This is important to avoid lengthy, detailed communication
- Coordination of Care communication needs to be pertinent information between the entire team
- Identify methods and how often:
  - Electronic, voicemail and/or face to face
- All coordination of care must be documented in the medical record

COMMUNICATION, COMMUNICATION, COMMUNICATION……

SUB-CONTRACTED DISCIPLINES

- Agency "owns" the patient and is responsible for coordination of care
- Hold your Sub-Contractors Accountable
  - Set up processes and meet with the company
  - 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 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
  - Each Team meets and discusses their shared patient case load
- Patients with ending episodes approaching in 2-3 weeks should be discussed as a team and a decision made to dc from care, dc 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 recert, it may become clear that one discipline should discharge, while another needs to recertify
- Be sure there is skilled need when recertify

DISCHARGE

- When discharging the patient, again ensure 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 and 5 Star Rating 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 (485) for this episode does not mirror your one from the last episode.

SCHEDULING IN AN EFFECTIVE CASE MANAGEMENT SYSTEM

- Empower your Clinicians to Manage Their Patients
  - Assign Patients to Clinician Teams
  - The team carries a Patient Caseload
  - Each clinician submits their weekly schedules to the agency

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
  - Ensure All contractors are submitting schedules in advance

SCHEDULING IN AN EFFECTIVE CASE MANAGEMENT SYSTEM

- Identify those qualified RNs to be Case Managers
  - Goal oriented, great organization and communication skills
- Form Teams consisting of Case Manager and Visit Nurses (RNs and LPNs)
- Assign All disciplines on a Case Management Team
  - Some disciplines have to cross over teams as volumes are low- Ai, ST, MSW

PROPOSED COPs - COORDINATION OF CARE KEY!

484.60- Care Planning and Coordination of Services

- The HHA must integrate services, whether services are provided directly or under arrangement, to assure
  - the identification of patient needs and factors that could affect patient safety and treatment effectiveness,
  - the coordination of care provided by all disciplines, and communication with the physician.
- The HHA coordinates care delivery to meet the patient's needs, and involves the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

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

Thank You!

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