





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





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



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**



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



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




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



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
 - Barthel index score less than 60



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
 - Barthel index score below 60



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





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




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





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





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




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



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



BLACKTREE
HEALTHCARE CONSULTING


BlackTree Healthcare Consulting 8/2017

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



BLACKTREE
HEALTHCARE CONSULTING



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


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




Case Management Weekly Roster

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




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



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





Revisions To Home Health CoP Impacting 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





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





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



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



Questions?



Contact

Diane Link RN, MHA
Director of Clinical Services
DianeLink@BlackTreeHealthcare.com
Office: (610) 536-6005 ext 775
Cell: (443) 340-4646

