Case Management Patient Communication Toolkit

Janet L. Blondo, MSW, CMAC, ACM, CCM

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Janet L. Blondo is the manager of case management at Washington Adventist Hospital in Takoma Park, Maryland, where she works alongside nurse and social work case managers. Her career in case management and social work has included a wide range of experiences. She has held positions as director, assistant director, manager, and supervisor of case management; social work manager; clinical supervisor; emergency department case manager; medical social worker; and social work consultant.

Blondo is passionate about case management and occasionally shares her knowledge through in-service educational programs. She has mentored those new to case management, served as a field instructor for both undergraduate and graduate social work students, and has educated nursing students interested in case management. She has a special affinity for creative problem solving and loves interdisciplinary collaboration.

A member of the American Case Management Association (ACMA), Blondo has served on the Board of the Maryland chapter of ACMA, planning educational programs for its members. Her interests in advocacy and public policy were strengthened by joining other ACMA members on Capitol Hill to urge Congressional support for issues benefiting senior citizens. She has also testified before the Maryland General Assembly to successfully change a state law on a health issue that she brought to the attention of her state delegate. She serves as the Membership Chair and is the new President-Elect of the Maryland ACMA.

Blondo received a bachelor of science degree in behavioral science with a psychology emphasis from Southern Adventist University in Collegedale, Tennessee, and a master's degree in social work from the University of Maryland in Baltimore. She resides in Clarksville, Maryland, with her husband Rick. She enjoys a lifelong love of learning and sharing her passion in case management with others.

CHAPTER 1

Screening, Assessments, and Documentation

Choosing criteria to identify patients who are likely to need help planning for postacute care needs and completing in-depth assessments can influence case management staffing patterns, budgets, and staffing mix. The combination of choosing the right screening criteria and completing quality assessments leads to implementing safe and timely discharge plans for patients. It can help increase patient satisfaction scores while lowering length of stay and readmission rates, thus lowering the cost of care. Good communication between the patient, case manager, and health-care team members is crucial to reaching population health goals. Documentation is not only a requirement for payment; its importance is also recognized by the Centers for Medicare & Medicaid Services (CMS) to ensure a safe and effective transition of care.

In 2013, CMS revised the standards for discharge planning for hospitals, known as the *Conditions of Participation* (*CoP*s). (These are the rules in effect at the time of publication, although new rules are anticipated later in 2016.) CMS also made suggestions for best practice standards that hospitals are encouraged, but not required, to follow. Many best practice suggestions are in the 2016 discharge planning proposed rule.

The *CoP*s state that evaluation and development of a patient's discharge plan must be conducted by a registered nurse, social worker, or other appropriate qualified person (experienced in discharge planning, resources, understanding functional status and need for equipment or postacute care), or by someone supervised by one of these three. The hospital's written policies must define the qualifications of the other appropriate person.

Who Do You Screen and Assess?

Currently, CMS requires a discharge planning process for all inpatients. The best practice suggestion is to include a discharge planning process for some *outpatients*, such as *observation patients*, patients discharged from *surgery for same-day procedures*, and *certain ED patients* who are determined to need discharge planning.

The discharge planning process includes:

- Screening all inpatients at risk of adverse health consequences after discharge if they have no discharge planning services
- Evaluating postacute care needs of patients identified above, those who self-identify, or those identified by physicians as needing a discharge plan
- Developing a discharge plan if needed or if a physician requests one
- Implementing the discharge plan prior to discharge (CMS, 2013)

The screening process in case management incorporates rounding, communicating with the multidisciplinary care team, and reviewing the chart. Rounding on a unit means briefly discussing each patient with the physician, physician advisor, nurse practitioner, specialist consultant, bedside nurse, therapist, dietitian, pharmacist, chaplain, or any other provider pertinent to the patient's situation. The screening process can also incorporate meeting with the patient and/or caregiver to ask a few questions.

Questions that need answers include:

- Is the patient alert and oriented and likely to remain that way at discharge (cognitive status)?
- Is the patient independent in functioning and likely to remain that way at discharge (functional status)?
- What are the patient's postacute healthcare needs?
- Do the patient's needs require a skilled healthcare professional or facility?
- If the patient has no skilled needs, will he or she be able to manage new or existing healthcare needs independently at discharge?
- If the patient cannot independently manage his or her healthcare needs post-discharge, is there a willing caregiver?

If the patient's postacute care needs can be met independently or without additional training or resources, perhaps no additional evaluation or assessment will be needed. If not, an assessment will be completed.

As there is no universal list of screening criteria, hospitals typically create their own list of criteria, which are characteristics commonly associated with patients at risk of adverse health consequences after discharge unless a discharge plan is put in place. Reviewing the chart and collecting these data helps the case manager determine who in the hospital needs evaluation.

Examples of screening criteria include:

- Age >75 and living alone or anyone >80
- Nursing home, assisted living facility, foster home, or group home residents
- Any homeless person
- Teen mother of a newborn
- Lack of maternal infant bonding
- Suspected victims of domestic violence, abuse, neglect, or exploitation
- Behavioral health or substance abuse diagnosis
- Frequent hospital encounters
- History of nonadherence to care plan
- Alteration in mental status diagnosis
- Diagnosis of new cerebral vascular accident or hip fracture
- New dialysis patient or newly diagnosed diabetic
- Patient diagnosed with congestive heart failure

- Patient with any diagnosis causing difficulty in functioning or coping, such as amyotrophic lateral sclerosis, Parkinson's disease, or cancer
- Patient with multiple fractures or trauma diagnosis

In addition to screening patients at risk for adverse health events without discharge planning services, the case manager receives and requests referrals for services or evaluation from the physician or other members of the care team and responds to requests for assistance from the patient and/or caregiver. There are even calls from community members—a neighbor, distant relative, or someone from adult protective services or from a child's school—alerting the case management team to some need.

When Do You Screen the Patients?

Case managers must identify patients in need of discharge planning at an early stage of hospitalization to allow time to develop and implement the discharge plan and avoid discharge delays (CMS, 2013). Therefore, the ideal time for screening patients for discharge planning needs to start before or at the time of admission or shortly after admission.

Case managers in the ED see patients who are frequent utilizers of services and who are identified for possible admission or to prevent a readmission. The patients are screened for discharge planning needs and an initial discharge plan is created by the time the decision to admit is made. Patients in observation status are also

screened for discharge planning needs. Many hospitals screen the joint replacement patients or patients with other planned surgeries for discharge planning needs prior to the patient's admission.

The CMS *CoP*s indicate that hospitals will be considered compliant if a patient is screened at least 48 hours prior to discharge and there is no discharge delay due to a delay in completing a discharge planning evaluation. There must be no evidence that a delay in evaluating a patient caused a change in his or her living environment.

Some patients initially identified in the screening process as not needing a discharge plan may have a change in condition while being hospitalized. The hospital then screens to determine if a discharge plan is needed and implements one as appropriate.

Screening, at a minimum, takes place each time rounding occurs. This can mean once every weekday on many hospital units or once per shift in hospitals with more than eight hours of daily coverage. Patients may also be evaluated following a request for a screening from the patient, family member, or healthcare provider due to a change in condition.

The Assessment and Initial Discharge Plan

When a patient is screened in, or found to be at risk of, an adverse event without a discharge plan, an in-depth assessment takes place of the patient's postacute care needs and his or her ability to meet

those needs, after which an initial plan is developed. Information is gathered not only from the patient but also from his or her family or someone from his or her prior residence. The patient's goals of care and preferences are considered when a discharge plan recommendation is made. Document patient/caregiver participation in planning as well as the patient's goals and preferences, agreement or disagreement with the plan, and any information given about services, postacute care coverage, and any application for Medicaid.

Whenever possible, make a plan for the patient to return to where he or she was living prior to the hospitalization. The results of the assessment and discharge planning recommendation are shared with the patient and the patient's support person. The patient must be given enough information about his or her condition, postacute care needs, and the options available to make an informed decision about his or her discharge plan. In some situations, the patient chooses not to participate with the discharge planning evaluation, and if this is so, it should be documented in the medical record and the case manager should determine if an alternate person is appropriate to work with in that circumstance.

Case managers should encourage active collaboration between the patient, the support person, the healthcare team, and the representatives from the postacute care companies or facilities. These companies or facilities are identified as possible providers of care for the patient so that the patient can ask questions and make the best decision possible for him- or herself.

A patient's condition must be monitored at least every 48 hours to prepare the patient, family, postacute facility, or service provider for discharge readiness but also to determine if an adjustment in the discharge plan is needed. Many hospitals monitor daily through rounding and care conferences, chart reviews, meetings with the patient, and other strategies. If a change in plans is needed because the patient's condition changed, document what led to the change and why the previous plan is no longer appropriate. The new plan should incorporate the patient's new care needs in the postacute period.

References

CMS. (2013). Revision to *State Operations Manual* (*SOM*), Hospital Appendix A - Interpretive Guidelines for 42 *CFR* 482.43, Discharge Planning. Retrieved February 15, 2016 from *www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-13-32.pdf.*

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The hospital case manager is the person many turn to when answers are scarce. A case manager can persuade the patient and family/caregiver to become actively involved in the plan of care, and he or she can draw upon resources when nothing seems possible. The information the case manager communicates to the patient, the family/caregiver, the hospital team, and the postacute care providers is paramount to getting the patient the right care in the right place at the right time and potentially avoiding a readmission. Communication is essential to the role of case management, yet crafting a universal message that both the patient and the case manager understand is a challenge for many hospitals.

The *Case Management Patient Communication Toolkit* helps to ensure case managers are delivering that universal message.

The toolkit is portable enough for case managers to use daily, and the included pocket card can easily be referenced while interacting with patients and families/caregivers.

This handbook provides more detailed information about the topics on the pocket card, including information about timing and language of notices as well as guidance about what to do when patients refuse to sign them.

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