Core Skills for Hospital Case Managers

A Training Toolkit for Effective Outcomes

Toni Cesta, PhD, RN, FAAN  •  Beverly Cunningham, MS, RN
List of Figures ........................................................................................................................................... xi

About the Authors ................................................................................................................................. xvii

Accessing the Tools and Templates on the CD-ROM .................................................................... xix

Chapter 1: Hospital Case Management 101: The Basics ................................................................. 1

What Is Case Management? .................................................................................................................. 1

Initial Drivers for Hospital Case Management ..................................................................................... 2

The integrated (dyad) model .................................................................................................................. 4

The collaborative (triad) model ............................................................................................................. 5

How are these models alike? .................................................................................................................. 7

Goals in Various Settings ....................................................................................................................... 8

Definition of case management ............................................................................................................ 9

Who is the case manager? .................................................................................................................... 9

Case management: The new generation ................................................................................................ 9

Chapter 2: Case Manager Role ............................................................................................................ 13

Skills of the Effective Case Manager ................................................................................................. 13

Supporting the Case Manager ............................................................................................................ 14

Orientation ........................................................................................................................................... 15

Preceptorship ....................................................................................................................................... 16

Keeping Case Management Staff Informed ......................................................................................... 16

Key Roles and Functions for Hospital Case Managers ......................................................................... 17

Role 1: Patient flow—coordination/facilitation of care ........................................................................ 17

Role 2: Utilization and resource management ..................................................................................... 18

Role 3: Denial management .................................................................................................................. 19
Role 4: Variance tracking ................................................................. 20
Role 5: Transitional and discharge planning ................................. 22
Role 6: Quality management .......................................................... 24
Role 7: Psychosocial assessment and counseling .......................... 27
Role 8: Regulatory requirements ..................................................... 28
Access Point Case Management ...................................................... 28
Admitting Department Case Management ........................................ 28
Coping with Medical Necessity on Admission ................................. 30
Emergency Department Case Management ..................................... 31
  Role 1: Gatekeeping .................................................................. 31
  Role 2: Initiation and facilitation of care ...................................... 31
  Role 3: Intake and utilization processes ....................................... 32
  Role 4: Encouraging the use of reimbursable diagnoses ............... 32
Other roles .................................................................................. 32
How to find patients ...................................................................... 33
Variance management in the emergency department .................... 33
Integrating case management and social work: Shared responsibilities ................................................................. 34
Measuring the success of the emergency department case manager .................................................................................. 35
Other Optional Functions: Clinical Documentation Improvement .............................................................................. 36
Role of the Social Worker ............................................................... 37
Role of the Discharge Planning Specialist ....................................... 39
Role of the Physician Advisor ........................................................ 40

Chapter 3: Roles, Functions, and Caseloads .................................. 45
Scope of Position ........................................................................... 45
  Payer mix .................................................................................. 48
  Intensity of service .................................................................... 48
  Complexity of patients ............................................................... 48
  Length of stay .......................................................................... 48
Determining Staffing Ratios in the Integrated Model ....................... 49
Determining Staffing Ratios in the Collaborative Model ..............................................................49
Determining the Number of Positions Needed for the Department ..............................................50
  Number of positions needed for integrated model ...............................................................51
  How many social workers do I need? ....................................................................................51
  Staffing for the emergency department in both models .......................................................52
  Social worker staffing in the emergency department ............................................................53
  Vacation/holiday/sick coverage .............................................................................................54

Chapter 4: The Case Management Process ..............................................................................57
Steps ..........................................................................................................................................57
  Step 1: Selection and screening ............................................................................................57
  Step 2: Patient assessment and diagnosis .............................................................................58
  Step 3: The case management plan ......................................................................................62
  Step 4: Linking the patient to needed services .....................................................................62
  Step 5: Implementation and coordination ............................................................................63
  Step 6: Monitoring of care processes ...................................................................................63
  Step 7: Advocacy ..................................................................................................................63
  Step 8: Evaluation and follow-up ..........................................................................................63
Medical Record Documentation ..................................................................................................63
  Where do I obtain the information for documentation? .........................................................65
  Ongoing documentation .......................................................................................................66
  Keeping Track of Your Information ......................................................................................68

Chapter 5: The Case Manager's Role in Transitional and Discharge Planning ........................71
Case Management’s Responsibility ..........................................................................................71
Operationalizing Discharge Planning .......................................................................................73
  Influences on the discharge plan: Patient ............................................................................73
  Influences on the discharge plan: Family .............................................................................75
  Influences on the discharge plan: Payer ................................................................................76
  Influences on the discharge plan: Physician ........................................................................77
Influences on the discharge plan: Processes ................................................................. 80
Influences on the discharge plan: Departmental staffing model ................................. 81
Influences on the discharge plan: Case manager/social worker relationships ............ 81
Influences on the discharge plan: Case manager and social worker skill sets .............. 84
Influences on the discharge plan: Manager/director ..................................................... 84
Influences on the discharge plan: Communicating with patients and families ............ 84
Influences on the discharge plan: Communicating with the interdisciplinary care team 84
Influences on the discharge plan: Patient safety events ............................................... 85

Process of Discharge Planning ....................................................................................... 85
Discharge planning triage process ................................................................................. 85
Internal solutions to discharge planning issues ............................................................. 89
External solutions to discharge planning issues ............................................................ 91

Hospital Discharge Planning: Helping Family Caregivers Through the Process .......... 92
Process Changes to Improve Discharge Planning ......................................................... 93
Factors related to placement decisions .......................................................................... 95

The Joint Commission and Discharge Planning ............................................................ 96
Measuring the Success of Discharge Planning ............................................................... 97

Chapter 6: Utilization Management .............................................................................. 101

Hospital Reimbursement ............................................................................................... 102
Payers ............................................................................................................................. 103
Reimbursement methods ............................................................................................... 103
Role of criteria ............................................................................................................... 104
Role of the case manager ............................................................................................. 104

Stages of UM Coordination ......................................................................................... 106
Stage 1: Assessment of severity of illness and intensity of service at admission .......... 106
Stage 2: Assessment of medical necessity for continued stay .................................... 110
Stage 3: Communication with the payer ....................................................................... 110
Stage 4: Discharge planning ......................................................................................... 116
The UM Process........................................................................................................................116

Physician advisor and the UM role ......................................................................................118

UM and the revenue cycle ..................................................................................................120

Time frames for utilization review .....................................................................................121

Regulations regarding UM .................................................................................................122

Managing UM for Medicare patients .................................................................................123

The Role of the Payers’ Contract with UM ..........................................................................128

UM outcome measures.......................................................................................................128

Chapter 7: Managing Long Length of Stay Patients.........................................................131

Definition of Long Length of Stay .....................................................................................131

Strategies for Ongoing Management of Long LOS Patients ..............................................132

Strategy 1: Identify long LOS patients and related issues ..................................................133

Strategy 2: Review LOS issues during interdisciplinary care rounds ..................................133

Strategy 3: Conduct weekly long LOS rounds ..................................................................133

Strategy 4: Determine which patients are acute and which are not ..................................135

Using Data to Identify and Understand Long LOS Patients ..............................................137

Chapter 8: Denials: Prevention and Appeals Strategies ....................................................141

What Causes Denials? .........................................................................................................143

Payers’ contribution to denied claims ................................................................................148

Case Management’s Role in Denials ...............................................................................150

Front-end processes ........................................................................................................150

Concurrent processes ......................................................................................................153

Back-end processes .........................................................................................................155

Understanding Denials Associated with a Case Manager’s Population .........................159

Chapter 9: Reimbursement ...............................................................................................163

Historical Precedence of Paying for Healthcare ...............................................................163

Payment Structure ...........................................................................................................165

Denial Process ..................................................................................................................167
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Reimbursement Challenges: Recovery Audit Contractors</td>
<td>173</td>
</tr>
<tr>
<td>Case managers’ role with RACs</td>
<td>174</td>
</tr>
<tr>
<td>Ongoing Reimbursement Challenges: Present on Admission</td>
<td>177</td>
</tr>
<tr>
<td><strong>Chapter 10: The Role of the Case Manager in Patient Flow</strong></td>
<td>183</td>
</tr>
<tr>
<td>A History of Patient Flow</td>
<td>183</td>
</tr>
<tr>
<td>Queuing theory</td>
<td>185</td>
</tr>
<tr>
<td>Demand and Capacity Management</td>
<td>186</td>
</tr>
<tr>
<td>Developing an Understanding of Patient Flow</td>
<td>187</td>
</tr>
<tr>
<td>Access</td>
<td>187</td>
</tr>
<tr>
<td>Throughput</td>
<td>190</td>
</tr>
<tr>
<td>Discharge</td>
<td>194</td>
</tr>
<tr>
<td>Using Variances to Identify and Correct Patient Flow Issues</td>
<td>195</td>
</tr>
<tr>
<td>Reporting variance data</td>
<td>198</td>
</tr>
<tr>
<td>Using the data</td>
<td>203</td>
</tr>
<tr>
<td>The patient flow scorecard</td>
<td>207</td>
</tr>
<tr>
<td><strong>Chapter 11: Measuring Success: Strategic Outcome Measures</strong></td>
<td>209</td>
</tr>
<tr>
<td>Measuring Outcomes</td>
<td>209</td>
</tr>
<tr>
<td>Process metrics and outcome metrics</td>
<td>210</td>
</tr>
<tr>
<td>What are your department’s goals?</td>
<td>211</td>
</tr>
<tr>
<td>Case Management Outcome Levels</td>
<td>211</td>
</tr>
<tr>
<td>Organizational outcomes</td>
<td>212</td>
</tr>
<tr>
<td>Length of stay</td>
<td>212</td>
</tr>
<tr>
<td>Third-party payer denials</td>
<td>213</td>
</tr>
<tr>
<td>Observation hours</td>
<td>214</td>
</tr>
<tr>
<td>Quality Outcome Metrics</td>
<td>214</td>
</tr>
<tr>
<td>Readmissions</td>
<td>215</td>
</tr>
<tr>
<td>Discharge and disposition delays</td>
<td>215</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>216</td>
</tr>
<tr>
<td>Inappropriate admissions</td>
<td>216</td>
</tr>
</tbody>
</table>
Contents

Service outcomes ...............................................................................................................216
Productivity Measures .........................................................................................................216
Other Metrics to Consider ..................................................................................................218
Comparing Your Outcomes Against National Benchmarks ..................................................219
  Benchmarking for length of stay .......................................................................................219
  Case-mix index ..................................................................................................................220
  Case management clinical benchmarks ...........................................................................220
  Case management service benchmarks ..........................................................................221
  Case management productivity benchmarks ....................................................................221
  Tracking cost avoidance ....................................................................................................221
Identifying Key Case Management Performance Metrics ....................................................222
The Case Management Department Report Card ..................................................................223

Chapter 12: Dealing with the Uninsured and Underinsured ...............................................227
  Identification of the Unfunded Patient ...............................................................................228
  Risks for unfunded patients ...............................................................................................228
  Undocumented aliens .........................................................................................................232
Underfunded Patients ..........................................................................................................232
  The unfunded multidisciplinary team ...............................................................................235
ED Case Management and Unfunded Patients ....................................................................236
Discharge Strategies for the Uninsured .................................................................................238
  Medical necessity and the unfunded patient ......................................................................241
Outcomes for Unfunded Patients .........................................................................................241

Chapter 13: Working with Multidisciplinary Teams ............................................................247
  Case study of a multidisciplinary team ............................................................................256

Chapter 14: Crucial Communication and Conflict Resolution ............................................261
  Hospital Clinical Departments ...........................................................................................264
  Patient access ....................................................................................................................264
  Physicians .........................................................................................................................264
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health information management</td>
<td>265</td>
</tr>
<tr>
<td>Peer case managers (internal)</td>
<td>265</td>
</tr>
<tr>
<td>Internal social workers</td>
<td>267</td>
</tr>
<tr>
<td>External case managers and social workers</td>
<td>267</td>
</tr>
<tr>
<td>Next level of care providers</td>
<td>268</td>
</tr>
<tr>
<td>Payers</td>
<td>268</td>
</tr>
<tr>
<td>Denial and appeal staff</td>
<td>269</td>
</tr>
<tr>
<td>CFO</td>
<td>269</td>
</tr>
<tr>
<td>Billing</td>
<td>270</td>
</tr>
<tr>
<td>Nursing</td>
<td>270</td>
</tr>
<tr>
<td>Patients</td>
<td>270</td>
</tr>
<tr>
<td>Families</td>
<td>271</td>
</tr>
<tr>
<td>Case management administration</td>
<td>271</td>
</tr>
<tr>
<td>Guest relations</td>
<td>271</td>
</tr>
<tr>
<td>Conflict</td>
<td>271</td>
</tr>
<tr>
<td>Communication in a High-Tech World</td>
<td>274</td>
</tr>
<tr>
<td>Electronic medical record</td>
<td>274</td>
</tr>
<tr>
<td>Electronic UM record</td>
<td>274</td>
</tr>
<tr>
<td>Automated communication through handheld devices</td>
<td>275</td>
</tr>
<tr>
<td>Automated medical necessity criteria</td>
<td>275</td>
</tr>
<tr>
<td>Electronic discharge planning</td>
<td>275</td>
</tr>
<tr>
<td>Electronic telephone messaging to physicians</td>
<td>275</td>
</tr>
</tbody>
</table>

**Continuing Education Instructional Guide**..........................279

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Education Exam</td>
<td>284</td>
</tr>
<tr>
<td>Continuing Education Evaluation</td>
<td>293</td>
</tr>
</tbody>
</table>
List of Figures

Chapter 1

Figure 1.1: Traditional case management model ................................................................. 3
Figure 1.2: Partially integrated case management model ..................................................... 3
Figure 1.3: Partially integrated case management model, version 2 ................................... 4
Figure 1.4: The integrated case management model ............................................................ 5
Figure 1.5: The collaborative (triad) model ...................................................................... 5
Figure 1.6: Advantages of each model .............................................................................. 6
Figure 1.7: Disadvantages of each model ......................................................................... 6
Figure 1.8: Benefits and concerns of staff nurses becoming case managers ....................... 10

Chapter 2

Figure 2.1: Case manager competence continuum ............................................................ 15
Figure 2.2: Correlation of utilization management and patient flow .................................. 19
Figure 2.3: Correlation with the addition of denial management ........................................ 20
Figure 2.4: Correlation with the addition of variance tracking ............................................. 22
Figure 2.5: Correlation with the addition of transition and discharge planning ................. 23
Figure 2.6: Correlation with the addition of quality management ....................................... 27
Figure 2.7: Correlation with the addition of psychosocial counseling ................................. 27
Figure 2.8: Issues of noncompliance ................................................................................ 34
Figure 2.9: Integrating case management and social work: Issues of nonpayment .............. 34
Figure 2.10: Integrating case management and social work: Obtaining medications ............ 35
Figure 2.11: Integrating case management and social work: Homeless patients ................ 35
Figure 2.12: Denial management activity report ................................................................. 41
Figure 2.13: Summary of denial management activity (To date) ........................................ 42
# List of Figures

## Chapter 3
- Figure 3.1: Template for rounds scripting ................................................................. 47

## Chapter 4
- Figure 4.1: High-risk criteria ....................................................................................... 58
- Figure 4.2: Case management department clinical intake/admission assessment form .......... 60
- Figure 4.3: Orientation worksheet for new case managers .................................................. 69

## Chapter 5
- Figure 5.1: Case manager and social worker role demarcation ........................................ 83
- Figure 5.2: Discharge planning triage process .................................................................. 86

## Chapter 6
- Figure 6.1: UM documentation tool ............................................................................... 109
- Figure 6.2: Primary payer list .......................................................................................... 112
- Figure 6.3: On-site UM payer staff communication tool ................................................... 113
- Figure 6.4: Lower rate negotiation process ....................................................................... 115
- Figure 6.5: Physician advisor communication tool .......................................................... 119
- Figure 6.6: The revenue cycle ......................................................................................... 120
- Figure 6.7: Best practice admission for Medicare patients ............................................... 124
- Figure 6.8: Medicare patient who does not meet medical necessity .................................... 125
- Figure 6.9: Best practice with no admission CM or protocol .......................................... 126
- Figure 6.10: Use of Condition Code 44 ......................................................................... 127

## Chapter 7
- Figure 7.1: Long LOS auditing and management tool ...................................................... 134
- Figure 7.2: Algorithm for managing long LOS patients .................................................... 136

## Chapter 8
- Figure 8.1: Anatomy of a bill ......................................................................................... 143
- Figure 8.2: Root causes of denials .................................................................................. 147
- Figure 8.3: Payers’ requirements for payment ................................................................. 148
List of Figures

Chapter 9

Figure 9.1: Patient process utilization management ................................................................. 166
Figure 9.2: Healthcare processes .............................................................................................. 168
Figure 9.3: Reimbursement discussions with patients ............................................................... 170
Figure 9.4: Financial and clinical outcomes ............................................................................. 172
Figure 9.5: Accountability at each entry point ......................................................................... 176

Chapter 10

Figure 10.1: What makes up access? ...................................................................................... 188
Figure 10.2: What makes up throughput? ................................................................................ 191
Figure 10.3: Perioperative process high level ........................................................................... 192
Figure 10.4: The drill-down process ......................................................................................... 196
Figure 10.5: Sample reasons for responsible parties ................................................................. 197
Figure 10.6: Avoidable days cross-walked to target DRGs ....................................................... 198
Figure 10.7: Variances by responsible party and reason ........................................................... 199
Figure 10.8: Overall system variances ..................................................................................... 200
Figure 10.9: System variances (subset of Figure 10.8) ............................................................. 201
Figure 10.10: System variances—in days ................................................................................. 202
Figure 10.11: Variances in pie graph format ............................................................................. 203
Figure 10.12: Trending the data by quarter .............................................................................. 203
Figure 10.13: Top variances for internal systems ..................................................................... 204
Figure 10.14: Variance data for external systems ..................................................................... 205
Figure 10.15: Variance data for patient and family ................................................................... 205
Figure 10.16: Variance data for payer ..................................................................................... 206
List of Figures

Chapter 11

Figure 11.1: Examples of financial outcome measures ............................................................ 212
Figure 11.2: Third-party payer denials ..................................................................................... 213
Figure 11.3: Other financial metrics ........................................................................................ 214
Figure 11.4: Quality outcome metrics ...................................................................................... 215
Figure 11.5: Staff productivity .................................................................................................. 217
Figure 11.6: Case manager report card .................................................................................... 217
Figure 11.7: Additional metrics ............................................................................................... 218
Figure 11.8: Case management financial benchmarks ............................................................. 219
Figure 11.9: Additional financial benchmarks ......................................................................... 219
Figure 11.10: Sample CMI analysis ......................................................................................... 220
Figure 11.11: Quality indicators ............................................................................................... 220
Figure 11.12: Key case management performance metrics ...................................................... 222
Figure 11.13: Case management report card ............................................................................ 224

Chapter 12

Figure 12.1: Uninsured patient process .................................................................................... 231
Figure 12.2: Complex patients with potential funding issues ..................................................... 234
Figure 12.3: Self-pay (unfunded) dashboard elements ............................................................... 238
Figure 12.4: Checklist questions for potential unfunded or underfunded patients ..................... 243
Figure 12.5: Questions to ask patients who have been identified as self-pay or their benefit coverage has expired ........................................................................................................ 244

Chapter 13

Figure 13.1: Focus areas of case manager–involved teams ....................................................... 248
Figure 13.2: Length of stay team plan ..................................................................................... 253
Figure 13.3: CFO length of stay team plan .............................................................................. 253
Figure 13.4: Accountability for length of stay team members ................................................ 254
Figure 13.5: Sample team plan for an unfunded or underfunded patients team ..................... 257
Figure 13.6: Unfunded or high-dollar multidisciplinary team member list ........................................ 258

Chapter 14

Figure 14.1: Communication circle identifying communication points for case managers .......... 262
Figure 14.2: Case manager’s role in advocacy ........................................................................... 263
Figure 14.3: Handoff communication checklist for hospital case managers ................................. 266
Figure 14.4: Handoff communication checklist for hospital case managers to external case managers ................................................................................................................. 267
Figure 14.5: Case manager communication scripting with physicians: What to say and what not to say .................................................................................................................. 273
Figure 14.6: Standardized communication with physicians .......................................................... 273
Figure 14.7: Communication checklist ...................................................................................... 276
About the Authors

**Toni Cesta, PhD, RN, FAAN**

*Toni Cesta, PhD, RN, FAAN,* is the senior vice president of operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY. Prior to this role, she was vice president of patient flow optimization at North Shore–Long Island Jewish Health System in Great Neck, NY.

Cesta is a partner and consultant at Case Management Concepts, LLC, in Dallas. She has been a national and international leader in the field of case management for 20 years and has authored seven books on the subject.

**Beverly Cunningham, MS, RN**

*Beverly Cunningham, MS, RN,* is vice president of clinical performance improvement at Medical City Dallas Hospital, where she is responsible for case management, quality, health information management, and patient access.

Cunningham is nationally known for her work in the area of case management and has presented seminars and spoken at national conventions. She has extensive experience in healthcare management. Through her consulting, she directs hospitals, physician groups, and other healthcare facilities to redesign delivery systems focusing on case management implementation through a focus on improved clinical and financial outcomes.
Files Contained on Your CD-ROM

To adapt any of the files to your own facility, simply follow the instructions below to open the CD. If you have trouble reading the forms, click on “View,” and then “Normal.” To adapt the forms, save them first to your own hard drive or disk (by clicking “File,” then “Save as,” and changing the system to your own). Then change the information to fit your facility, and add or delete any items that you wish to change.

The following file names on the CD-ROM correspond with tools listed in the book:

<table>
<thead>
<tr>
<th>File name</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig 1-6</td>
<td>Advantages of each model</td>
</tr>
<tr>
<td>Fig 1-7</td>
<td>Disadvantages of each model</td>
</tr>
<tr>
<td>Fig 1-8</td>
<td>Benefits and concerns of staff nurses becoming case managers</td>
</tr>
<tr>
<td>Fig 2-1</td>
<td>Case manager competence continuum</td>
</tr>
<tr>
<td>Fig 2-12</td>
<td>Denial management activity report</td>
</tr>
<tr>
<td>Fig 2-13</td>
<td>Summary of denial management activity</td>
</tr>
<tr>
<td>Fig 3-1</td>
<td>Template for rounds scripting</td>
</tr>
<tr>
<td>Fig 4-1</td>
<td>High-risk criteria</td>
</tr>
<tr>
<td>Fig 4-2</td>
<td>Case management department clinical intake/admission assessment form</td>
</tr>
<tr>
<td>Fig 4-3</td>
<td>Orientation worksheet for new case managers</td>
</tr>
<tr>
<td>Fig 5-1</td>
<td>Case manager and social worker role demarcation</td>
</tr>
<tr>
<td>Fig 6-1</td>
<td>UM documentation tool</td>
</tr>
<tr>
<td>Fig 6-2</td>
<td>Primary payer list</td>
</tr>
<tr>
<td>Fig 6-3</td>
<td>On-site UM payer staff communication tool</td>
</tr>
<tr>
<td>Fig 6-4</td>
<td>Lower rate negotiation process</td>
</tr>
<tr>
<td>Fig 6-5</td>
<td>Physician advisor communication tool</td>
</tr>
<tr>
<td>File name</td>
<td>Document</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Fig 7-1</td>
<td>Long LOS auditing and management tool</td>
</tr>
<tr>
<td>Fig 7-2</td>
<td>Algorithm for managing long LOS patients</td>
</tr>
<tr>
<td>Fig 8-2</td>
<td>Root causes of denials</td>
</tr>
<tr>
<td>Fig 8-3</td>
<td>Payers’ requirements for payment</td>
</tr>
<tr>
<td>Fig 8-6</td>
<td>Denial management tracking and evaluation tool</td>
</tr>
<tr>
<td>Fig 8-7</td>
<td>Evaluation tool for denials caused by the facility</td>
</tr>
<tr>
<td>Fig 8-8</td>
<td>Denial reason codes</td>
</tr>
<tr>
<td>Fig 9-2</td>
<td>Healthcare processes</td>
</tr>
<tr>
<td>Fig 9-3</td>
<td>Reimbursement discussions with patients</td>
</tr>
<tr>
<td>Fig 10-5</td>
<td>Sample reasons for responsible parties</td>
</tr>
<tr>
<td>Fig 10-6</td>
<td>Avoidable days cross-walked to target DRGs</td>
</tr>
<tr>
<td>Fig 10-7</td>
<td>Variances by responsible party and reason</td>
</tr>
<tr>
<td>Fig 10-8</td>
<td>Overall system variances</td>
</tr>
<tr>
<td>Fig 10-9</td>
<td>System variances (subset of Figure 10.8)</td>
</tr>
<tr>
<td>Fig 10-18</td>
<td>The patient flow scorecard</td>
</tr>
<tr>
<td>Fig 11-6</td>
<td>Case manager report card</td>
</tr>
<tr>
<td>Fig 11-7</td>
<td>Additional metrics</td>
</tr>
<tr>
<td>Fig 11-12</td>
<td>Key case management performance metrics</td>
</tr>
<tr>
<td>Fig 11-13</td>
<td>Case management report card</td>
</tr>
<tr>
<td>Fig 12-1</td>
<td>Uninsured patient process</td>
</tr>
<tr>
<td>Fig 12-2</td>
<td>Complex patients with potential funding issues</td>
</tr>
<tr>
<td>Fig 12-3</td>
<td>Self-pay (unfunded) dashboard elements</td>
</tr>
<tr>
<td>Fig 12-4</td>
<td>Checklist questions for potential unfunded or underfunded patients</td>
</tr>
<tr>
<td>Fig 12-5</td>
<td>Questions to ask patients who have been identified as self-pay or their benefit coverage has expired</td>
</tr>
<tr>
<td>Fig 13-2</td>
<td>Length of stay team plan</td>
</tr>
<tr>
<td>Fig 13-3</td>
<td>CFO length of stay team plan</td>
</tr>
<tr>
<td>Fig 13-4</td>
<td>Accountability for length of stay team members</td>
</tr>
<tr>
<td>Fig 13-5</td>
<td>Sample team plan for an unfunded or underfunded patients team</td>
</tr>
<tr>
<td>Fig 13-6</td>
<td>Unfunded or high-dollar multidisciplinary team member list</td>
</tr>
</tbody>
</table>
**File name** | **Document**  
--- | ---  
Fig 14-3 | Handoff communication checklist for hospital case managers  
Fig 14-4 | Handoff communication checklist for hospital case managers to external case managers  
Fig 14-5 | Case manager communication scripting with physicians: What to say and what not to say  
Fig 14-7 | Communication checklist  

**Bonus files**
In addition, the CD-ROM contains the PowerPoint slides found in Chapter 7, so that you can create your own long length of stay data presentation, and a sample tool to document your facility’s entry points:

**File name** | **Document**  
--- | ---  
LOSdata | PowerPoint presentation from Chapter 7: Managing Long LOS Patients  
EntryPoints | Sample tool to document your entry points  
ComPoints | Sample tool to document your organization’s communication points  

**Installation Instructions**

This product was designed for the Windows operating system and includes Word files that will run under Windows 95/98 or later. The CD will work on all PCs and most Macintosh systems. To run the files on the CD-ROM, take the following steps:

1. Insert the CD into your CD-ROM drive.

2. Double-click on the “My Computer” icon, next double-click on the CD drive icon.

3. Double-click on the files you wish to open.

4. Adapt the files by moving the cursor over the areas you wish to change, highlighting them, and typing in the new information using Microsoft Word.

5. To save a file to your facility’s system, click on “File” and then click on “Save As.” Select the location where you wish to save the file and then click on “Save.”

6. To print a document, click on “File” and then click on “Print.”
What Is Case Management?

Case management is a model of care delivery that incorporates aspects of quality of care and cost containment. The history of case management is a long and diverse one that began long before hospitals started incorporating it into their delivery systems. Evidence of the use of case management goes back as far as the 1920s. Its origins are from community settings, including psychiatry, social work, and public health nursing.

It was not until the advent of the acute care prospective payment system (PPS) in the early 1980s that hospitals began to consider the need to address issues such as length of stay, cost per case, and the continuum of care (Cesta & Tahan, 2003). Cost and reimbursement were the drivers that moved case management from a community-based model to one that includes hospital settings. The principles and goals of case management are consistent, regardless of the setting in which they are applied.
Initial Drivers for Hospital Case Management

PPS reimbursement methods for Medicare patients initiated the need for hospitals to think differently about how they organized their care. The advent of the diagnosis-related groups (DRG) in the early 1980s introduced a new and very different way in which hospitals would be reimbursed.

Gone were the indemnity reimbursement methods in which a hospital was paid in equal kind for services rendered. The federal government had essentially put hospitals on a budget, telling them that a fixed amount would be reimbursed, regardless of dollars spent. If the hospital was able to deliver the care spending less than the fixed amount, they were able to keep the difference. If they spent more than the allowed amount, they had to absorb that additional cost. This paradigm shift required a quick and different approach to how hospitals did business. Length of stay as well as cost per stay became important as hospitals had to balance their costs against the fixed reimbursement amounts they were receiving.

Following behind Medicare’s reimbursement changes, many states adopted similar payment schemes for their Medicaid programs. The majority of patients reimbursed under a government program were now within the PPS.

Within a few years, and as healthcare costs continued to rise, managed care organizations began to offer healthcare benefit packages to employers at lower premium costs than had been offered under the indemnity programs. Although managed care had been around for decades, it wasn’t until the late 1980s that it began to become increasingly popular. Its popularity directly correlated to the rising cost of healthcare throughout the United States. With increasing percentages of managed care penetration, a continued focus on length of stay management and cost containment remained critical to the financial viability of hospitals. It became clear that modifications to existing delivery methods that preceded prospective payment were essential. With this began a watershed moment in hospital case management. The majority of hospitals began to develop some form of hospital case management, and this rapid increase in case management brought problems. There were no national standards set as yet for models, staffing ratios, or outcomes. Each hospital attempted to take their existing structures and modify them.

Most started with the traditional case management models, which looked something like Figure 1.1.
Utilization review, performed by nurses, was separate from discharge planning, performed by social workers. The two roles did not intersect and had little relationship to each other. In fact, prior to the introduction of PPS and managed care, there was little need for an integrated approach to these functions. Once the reimbursement structures changed, the delivery models also had to change (Zander, 2008).

At this point, we began to see some attempts at interfacing the roles of utilization management and discharge planning. Partially integrated models looked something like Figure 1.2.

These models began to integrate the previously disconnected functions of utilization review to include utilization management and coordination and facilitation of care. These functions began to intersect with discharge planning, which was managed by the social worker in these early models.

As discharge planning began to become more clinically complex, and as patients’ psychosocial needs needed to be addressed, a shift began to take place in the management of the discharge planning processes. Some hospitals began to consider moving some of the discharge planning functions to the nurse case manager so the social worker could
spend more time dealing with patient psychosocial issues. At the same time, this would allow the nurse to manage the more clinically complex discharge planning activities, such as home care placements and subacute and home infusion therapy. The need to relate patients’ clinical needs to their level of care and their discharge plan drove this change forward.

Now, some of the models began to look like Figure 1.3.

![Partially integrated case management model, version 2](image)

By the mid-1990s, hospitals began to move toward more fully integrated models. Today, we see two versions of these integrated models: the integrated (dyad) model and the collaborative (triad) model.

**The integrated (dyad) model**

The integrated model represents a fully integrated model in which all core functions of case management are managed by the case manager. It represents one of the state-of-the-art models in use today. In this model, all case management roles are performed by a single case manager. The model integrates all previously disconnected roles and functions. In the integrated model, the nurse case manager and social worker work collaboratively on the most complex cases.

If you are a case manager working within this type of structure, you will be managing the patients meeting case management criteria and bringing in the social worker on the cases that meet the social worker’s high-risk criteria. In this model, not all patients will be followed by a social worker. The patients that will be followed will depend on which of the patients meet the high-risk criteria. In the dyad model, the case manager is responsible for some additional roles. These include the addition of discharge planning and variance management (see Chapter 5).

In the dyad model, the social worker may be responsible for some discharge planning functions or may be solely responsible for psychosocial assessments and interventions. This will depend on how the model is structured in a particular hospital.

In this model, usually around 30%–40% of all patients will meet the social worker high-risk criteria and will be followed by a social worker in addition to a case manager (see Figure 1.4).
The collaborative (triad) model
The collaborative or triad model adds a third key player to the core case management team. In this model, the clinical and business functions of case management are separate roles with the three team partners working actively together. The case manager is not responsible for the business functions, including utilization management (UM), obtaining authorizations, managing observation status, denial management, and clinical documentation improvement. Instead, these roles are performed by the UM/DRG manager. The UM/DRG manager primarily works the business side of case management, including intense review of documentation. The UM/DRG manager is the liaison between the team members and the regulatory and payer entities.

The case manager is responsible for risk screening, assessment and planning, coordination of care, resource management, and outcomes management. By separating the business roles from the clinical roles of case management, the case manager can spend more time dealing with complex clinical issues instead of payer or reimbursement issues.

In this model, the social worker performs very similar functions to those described in the integrated model. These include screening of patients, assessment and planning, brief therapeutic interventions, care planning, and crisis intervention. For high-risk cases, the social worker would assist with discharge planning activities as needed (see Figure 1.5).

The key difference between these case management models is the integration of UM into the case manager role versus separate UM/DRG specialist roles. Since both models are considered state of the art, each hospital has to determine which model will best help them achieve their expected outcomes.
All models have advantages and disadvantages. The decision to select one model over the other will depend on many factors that must be taken into consideration. To facilitate this decision, Figure 1.6 shows the advantages of each model.

As in all models, there are disadvantages as well. Listed in Figure 1.7 are the disadvantages of each model.

The integrated model requires less handing off from one member of the team to the next, thereby reducing duplication and redundancy. Data is collected once and used for multiple purposes. Conversely, in the collaborative model, the case manager is not consumed by payer functions throughout the day and is in a better position to leverage the work as needed. The collaborative model also allows for a greater focus on DRG management and documentation because these functions are discrete and separate from those of the case manager.
**How are these models alike?**

Both of these models build on the relationships between disciplines to enhance and achieve the case management outcomes. Both models require strong social work involvement on the most psychosocially complex patients. In addition, both are dependent on appropriate staffing ratios. In fact, the success of any model will depend on an adequate infrastructure, including appropriate staffing ratios. These ratios will depend on many factors, which are discussed in Chapter 3. The staffing ratios and the model design are the foundation of any case management department. Without this foundation, the department will crumble and never have an opportunity to achieve its outcomes.

Here are the four most important elements of any case management model:

- Adequate staffing
- Balanced workload
- Skilled staff members
- Strong leadership

Case management is used in hospitals today to promote quality, safe, and cost-effective care. It does this by promoting appropriate utilization of available resources to achieve financial and clinical outcomes. Case management in hospitals is also designed to ensure that patients have appropriate access to care. Case managers work collaboratively with patients, families, physicians, payers, and other members of the care team to develop and implement plans that meet patients’ goals and needs. Finally, case managers interject objectivity and healthcare choices while promoting self-care wherever possible.

Today, case management can be found in virtually all settings across the continuum of care, including:

- **Acute care**: Focus on the utilization of resources and discharge planning
- **Community**: Focus on primary care, wellness, prevention, and health maintenance
- **Home care**: Focus on chronic care management and self-management
- **Subacute care**: Focus on restoration and rehabilitation
- **Long-term care**: Focus on chronic and supportive care management
- **Disease management**: Focus on population risk stratification and chronic care management
- **Managed care**: Focus on UM, discharge planning, and gatekeeping
Core Skills for Hospital Case Managers

Functions that may appear to be intangible to the outside observer or to the novice case manager. In addition to this, we find that there are a variety of hospital case management models in use today. Many of these models have commonalities among them, but there is no one model that is considered the best. The choice of a model must be based on many factors, which we will review later.

Case management is only one of several models used to ensure that care is delivered to patients in an organized and efficient way, ensuring that quality of care is managed and maintained. Other disciplines use models as well. For example, the department of nursing uses a specific model of care delivery, such as primary nursing or team nursing. The department of medicine also uses a model of care delivery that organizes the ways in which medical care is delivered. In fact, virtually all clinical departments use a model to guide their workflow, and case management is no different.

A case management model in the hospital setting brings together several roles and functions that were used in hospitals before case management but previously did not interface with each other. Prior to the implementation of prospective payment, these roles and functions were performed independently of each other and were not integrated. After the advent of prospective payment, methods to control cost and maintain outcomes had to be developed.

**Goals in Various Settings**

Regardless of where case management is performed, its goals are universal:

- Improve patient satisfaction
- Coordinate care
- Reduce over- and underutilization of resources
- Maintain open communication
- Collaborate across the continuum of care

Today, the majority of case managers work in the hospital or acute care setting. Case management in the hospital setting uses a model of care that incorporates several roles and functions. In this context, we need to understand what a model of care actually is. Let’s think of a model as a description of something that cannot actually be seen or observed. In fact, this is one of our greatest challenges in case management today, to describe a set of roles and functions that may appear to be intangible to the outside observer or to the novice case manager. In addition to this, we find that there are a variety of hospital case management models in use today. Many of these models have commonalities among them, but there is no one model that is considered the best. The choice of a model must be based on many factors, which we will review later.

**Telephonic**
Focus on triage, giving advice, and gatekeeping

**Independent/private**
Focus on disability and chronic care management

**Worker’s compensation**
Focus on rehabilitation services and return to work (Cesta & Tahan, 2003)
for hospitals to survive the reductions in reimbursement that they were experiencing. This resulted in the development of the first hospital case management models and the integration of these roles and functions. This integration resulted in a care delivery model whose sum is greater than its parts.

Despite the fact that case management has been in the hospital setting for more than 20 years, confusion remains as to the fundamentals of what it is, how it works, and how it can affect patient care, outcomes, and cost. It is best to start with a definition that will provide the frame of reference for the remainder of this book.

**Definition of case management**

*A clinical model used for the strategic management of quality and cost of care, designed to facilitate the achievement of expected patient outcomes within an appropriate length of stay and with appropriate management of resources.*

*(Cesta, 2009)*

Although there are many definitions of case management found in the literature and defined by hospitals themselves, this is the definition that we will use as we continue our discussion. This definition incorporates all the elements of contemporary case management, most particularly the notion that case management is a model that incorporates the management of both quality and cost of care. You might think of case management as a bridge that connects healthcare’s clinical world to its financial world.

Now that we have a working definition and goals for case management, we can begin to discuss the key roles for the hospital case manager. We will start by describing who case managers are.

**Who is the case manager?**

Today’s case managers come from many clinical backgrounds as diverse as nursing itself. However, the origins of hospital case management really began with a transition of utilization review nurses to case managers. As the role of the case manager evolved and grew, utilization review nurses were joined by discharge planning nurses, clinical nurse specialists, and staff nurses. However, the majority of the first generation of case managers did have a background in utilization review.

**Case management: The new generation**

Today, we have to consider where the next generation of case managers will be found. Clearly, they are staff nurses working at the bedside. There are positives as well as negatives in transitioning staff nurses to case managers. Figure 1.8 reviews the benefits and concerns for a staff nurse moving from the bedside into a case manager role.
For example, the staff nurse will perform a physical assessment, administer medications, change dressings, and perform patient education activities, among other things. Conversely, the case manager is involved with the relationships between patients’ clinical conditions, their psychosocial issues, and their financial issues.

The staff nurse is able to “hand off” a patient at the end of his or her shift, and the next shift can pick up and continue with the care activities, education, and so on. The case manager typically does not have a next shift to pass the patient to, so activities that must be completed that day must be handled by that case manager before he or she can leave for the day. Because of this, time management and prioritization are important skills for the case manager (see list of skills in Chapter 2). So many of the functions case managers perform are extremely time-sensitive. For example, clinical reviews submitted to the third-party payer must usually be submitted by a certain hour of the day. If that time deadline is missed, the hospital is at risk for nonpayment.

Discharge planning activities are also time-sensitive. The patient should be discharged from the hospital when clinically ready to do so. Discharges occur throughout the day, the evening, and on the weekends. The case manager has to anticipate those

Probably the greatest challenge for the staff nurse transitioning to the role of case manager is the shift in clinical focus. Understanding the clinical condition of the patient is critically important for the case manager, but the focus is different. Whereas the staff nurse is concerned with direct patient care activities, the case manager is concerned with indirect patient care activities.

Figure 1.8

Benefits and concerns of staff nurses becoming case managers

<table>
<thead>
<tr>
<th>Benefits of becoming a case manager</th>
<th>Concerns about leaving staff nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical expertise</td>
<td>Has benefit of overtime and after-hours and weekend differentials</td>
</tr>
<tr>
<td>Familiarity with acute care</td>
<td>Transition to a wider view of the patient—plan for stay as well as for the day</td>
</tr>
<tr>
<td>Understands coordination of care processes</td>
<td>Ability to negotiate with families, physicians, payers, others</td>
</tr>
<tr>
<td>Transitions from hourly to salaried position</td>
<td>Knowledge of:</td>
</tr>
<tr>
<td>Flexible schedule</td>
<td>– UM</td>
</tr>
<tr>
<td></td>
<td>– Discharge planning</td>
</tr>
<tr>
<td></td>
<td>– Compliance</td>
</tr>
<tr>
<td></td>
<td>– Rules and regulations</td>
</tr>
</tbody>
</table>

Core Skills for Hospital Case Managers © 2009 HCPro, Inc.
discharges and prepare accordingly. The ability to juggle many different activities at the same time is an important skill for case managers to have.

Case managers must work collaboratively with virtually all members of the interdisciplinary healthcare team. In addition, they must work with outside resources such as nursing homes, subacute facilities, and home care agencies. They also must be able to work with third-party payers. The universe of the case manager is much larger than that of the staff nurse, extending beyond the boundaries of the hospital. An effective case manager must be able to see that bigger picture and work accordingly.

All nurses and social workers are familiar with The Joint Commission standards and regulations as they pertain to their role. For the case manager, different standards may apply. The case manager must also be familiar with other healthcare regulations, such as:

- Conditions of Participation from Medicare for Discharge Planning
- Conditions of Participation from Medicare for Utilization Management
- Emergency Medical Treatment and Active Labor Act (EMTALA)
- State insurance laws
- Coverage issues for patients under their managed care plan, Medicare, and Medicaid
- Legal issues pertaining to discharge planning

An understanding of these rules and regulations extends beyond the staff nurse’s foundation of knowledge and represents critical knowledge skills that a case manager must have.

Because case managers manage patient care processes toward expected outcomes, they must have a working knowledge of data, including what data need to be collected, how data are managed, and how they are disseminated. This increased focus on data allows case managers to understand how their interventions affect the patient and the organization, and to adjust their work accordingly (see Chapter 8).

Staff nurses considering a transition to the role of case manager must take into account many factors. One of the principal areas of consideration is their comfort level in being removed from direct patient care. This may be a difficult or impossible transition for some nurses. Because so much of the role of the case manager may not be obvious to the staff nurse observer, he or she may want to consider spending some time shadowing a case manager to get a feel for the role. This may be time well spent. The staff
nurse should also inquire as to what orientation will be provided and the length of that orientation. The staff nurse may want to take some time to read journal articles on case management, interview case managers currently working in the field, and gather any other information he or she can, such as a job description, before making the decision to transition to this next level of his or her career.

The next chapter discusses the skills, roles, functions, and competencies of case managers.

REFERENCES


Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit [www.hcmarketplace.com](http://www.hcmarketplace.com). If you received a special offer or discount source code, please enter it below.

<table>
<thead>
<tr>
<th>Title</th>
<th>Price</th>
<th>Order Code</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your order is fully covered by a 30-day, money-back guarantee.

cono* Enter your special Source Code here:

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
<th>Order Code</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Shipping*       | $       | (see information below) |
| Sales Tax**     | $       | (see information below) |
| Grand Total     | $       |                         |

**Shipping Information**
Please include applicable shipping. For books under $100, add $10. For books over $100, add $18. For shipping to AK, HI, or PR, add $21.95.

**Tax Information**
Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

States that tax products only: AZ.

BILLING OPTIONS:

- **Bill me**
- **Check enclosed (payable to HCPro, Inc.)**
- **Bill my facility with PO # ________________**

**Bill my (✓ one):**
- **VISA**
- **MasterCard**
- **AmEx**
- **Discover**

Signature: ____________________________
Account No.: _________________________
Exp. Date: __________________________

(Required for authorization) (Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at [www.hcmarketplace.com](http://www.hcmarketplace.com)

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945
CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787
FAX THE COMPLETED ORDER FORM TO: 800/639-8511
E-MAIL: customerservice@hcpro.com

© 2008 HCPro, Inc. HCPro, Inc. is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks. Code: EBKPDF