Partnering with the Care Management Department

March 2017
Department of Care Management

- Physician Advisors
- Inpatient Case Managers
- Social Workers
- Utilization Managers
- Lee Health Solutions

"Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self determination." ACMA 2002
Roles of Care Management

- Patient advocacy
- Clinical coordination
- Safe discharge planning
- Regulatory compliance
- Provide clinical information to insurance companies as requested
- Denials management
- Utilization review
- Data collection (delays, readmission reasons)
- Collaboration with local community social service agencies/SNF/HH agencies.
Care Coordination

- Assures coordination of resources to meet patient needs and facilitates movement across the continuum of care in a cost effective manner
- Medically Complex cases
- Frequent hospitalizations / Chronic disease
- Educational needs associated with newly diagnosed conditions
- Post-acute needs and follow-up
- Crisis intervention / Advance Directives
- Baker Acts
- Length of Stay monitoring
- Identification & resolution of disposition barriers

- Our Goal: ensure a safe transition of care and prevention of readmission
Discharge Planning

- Home Health and DME orders now contain a “Face to Face” requirement which documents the rationale for a patient's homebound status
- Acute Rehabilitation Hospital placements
- Skilled Nursing Facility (SNF)--transfers requiring Class II or greater Narcotic’s must have an original prescription written on watermarked paper or they will not receive this medication
- Home Health Services
- Long Term Acute Care Hospital placements
- Assisted Living Facility (ALF) placements
- Outpatient Infusion / Wound Care
- Lee Health Interim / Infusion Center / Coumadin (Lovenox) Clinic
- Community Social service agencies
- Outpatient therapy
Physician Advisor

- Collaborates with attending physicians to identify and resolve issues regarding clinical appropriateness, resource utilization and appropriate alternatives
- Assist attending physicians in utilization management decision and placement
- Serves as an advisor on complex cases
- Serve as a champion and resource for the Care Management program
- Reviews referred cases for medical necessity, quality and documentation.
- Denial review and appeals

- Cape Coral Hospital: Dr. Jon Hart
- Gulf Coast Medical Center: Dr. Alex Paya
- HealthPark Medical Center: Dr. Robert Brown
- Lee Memorial Hospital: Dr. Anita Shinde
Physician Documentation Supportive of Inpatient Admission

- Severity, risk and service intensity supporting need for hospitalization
- Failed outpatient treatment – what was tried and did not work?
- Complexity of signs and symptoms
- Evidence of instability or high risk of complications or mortality
- Advanced age / multiple co-morbidities
- Based on your documentation, clinical information is provided to the insurers who authorize payment (or not)
- We may request your assistance in speaking to a plan’s medical director, as needed, to defend a case
- Update plan of care daily
Medicare Observation vs Inpatient Status

- Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision as to whether the patient will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital.
- Billed under Part B as outpatient
- In general, the Two-Midnight rule stated that Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.
- The Two-Midnight specifies that all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service. (Excludes Inpatient Only Procedures)
Case Management Protocol

- As approved by MEC, the following orders may be initiated by Case Management based on their assessment of the patients’ needs during the hospital stay to assist with discharge planning:
  - PT / OT / Speech therapy to eval and treat
  - FIT team evaluation
  - The Rehabilitation Hospital eval
  - Durable Medical Equipment: walker, bedside commode, wheelchair
  - Ostomy nurse consult
  - Cardiac / Pulmonary rehab eval
  - Neurologic checks every 4hrs x 24hrs
  - Room air saturation levels and home oxygen if documentation supports
Tips for successful collaboration

- Please discuss with patients observation status while still in the ED. Do not use the word “admit”.
- RX assist protocol for “financial assistance” patients
- Please provide RX scripts for high cost meds early so we can run it and obtain prior auth if needed. You may receive calls from pharmacy requesting to change medications to something more cost effective or covered on patient’s insurance.
- Required signed scripts for narcotics for SNF patients
- Required signed scripts for insulin for patients obtaining this from Lee Co Health Dept
- Tertiary facilities- your role in obtaining a provider, our role then to work with the facility
- We may request a peer to peer review for appeals, requesting favors of specialists. Much more effective if provider intervenes with medical directors rather than CM calling.
- Please write the dc order when patient is medially ready even if we don’t have a SNF bed or services in place because we track avoidable days.
- Signing SNF form # 3008 and ALF form #1823 24 hours prior to d/c to prevent delays
Lee Health Solutions 424-3120

- Chronic Disease Self Management Classes “It’s All About You”
  - Meet at various locations throughout our community
  - Teaches how to self-manage chronic diseases

- Chronic Pain Self Management
  - Meet at various locations throughout our community
  - Teaches how to self-manage chronic diseases

- Lee Diabetes Care
  - Inpatient and outpatient diabetes education provided by Certified Diabetes Educators (RNs and RDs)
  - Recognized by the American Diabetes Association since 1987

- Lee Center for Weight Management
  - Offers individual and group sessions
  - Facilitated by Registered Dietitians
  - Complete Health Improvement Program (CHIP)
    - Reduce disease risk factors through the adoption of better health habits and appropriate lifestyle modifications.
Thank You