

Partnering with the Care Management Department

**Medical Staff and Allied Health
Practitioner Orientation**

Department of Care Management

- Medical Directors of Care Coordination
- Inpatient Case Managers
- Social Workers
- Utilization Managers
- Lee Health Solutions
- Transfer Center

Roles include: 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 pt’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
- 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

2016 FY Update to Two MN Rule (excluding IP only procedures)

- For stays expected to last less than two midnights – CMS proposes the following:
 - An inpatient admission would be payable **on a case-by-case basis**. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
 - CMS reiterates that **it would be rare and unusual for a beneficiary to require inpatient hospital admission for a period of time that is only for a few hours and does not span at least overnight**.
 - CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

Observation 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
- Decision to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

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

Lee Health Solutions 424-3120

- Chronic Disease Management Classes “It’s All About You”
- Chronic Pain Self Management
 - Meet at various locations through out 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
 - Available for use: Glucomander is a computerized algorithm-based system used to resolve hyperglycemia within 6-12 hours and to then maintain normoglycemia. It is used in combination with IV insulin infusion and a bedside blood glucose monitor
- Lee Center for Weight Management
 - Offers individual and group sessions
 - Facilitated by Registered Dietitians

Transfer Center

239-343-2370

- Open 24 hours a day / 7 days a week
- Coordinates all transfers between campus sites, into and out of the system
- Reviews all direct admissions for level of care, type of bed and confirmation of the reported accepting MD/Hospitalist based on clinicals from the physician's office

You may call the Transfer Center at any time for help
with a transfer or direct admit