THE TEN Cs OF CASE MANAGEMENT

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Article I. Case Management is the set of processes through which all health related matters of care are managed by a physician, nurse or a designated health care professional. The Case Manager(s) coordinate specified components of health care, such as appropriate referral to consultants, specialists, hospital, ancillary providers and all additional services (placement in Skilled nursing facility or assisted living community for example). Case management is meant to ensure continuity of services and accessibility, and as a means to overcome rigidity, fragmented services (help consumer navigate the fragmented health care system), and the misuse of facilities and resources. It also tries to match the appropriate intensity of services with the patient's needs over time hopefully ensuring the compliance of the managed care philosophy of "Right Place, Right Time for the Right Price".

Article II. Initially Case Management was a tool applied by payers to manage the benefit dollar. Today it is a concept that enhances the care process helping to ensure the proper care planning is followed and education provided the customers (families and patients alike) to maintain buy-in in the healing /recovery process.

Case Management starts with the Coordination of Care placing the patient in the most appropriate care setting. Ideally this placement is monitored and the patient moved through the care continuum as needs change and healing occurs returning him to health or a healthier status. To ensure complete payment of the bill, even before placement occurs, benefits must be verified, to verify the coverage for the care approved by the payer to the provider, even if it is a secondary payer.

To ensure placement in the most appropriate setting, a pre-admission evaluation is performed as the very first step to begin the Coordination of care cycle. Through the initial evaluation a baseline of services needed is created. This leads to an estimated length of stay and the beginning of the initial comprehensive care plan.

The Case management cycle proceeds with the complete development of a comprehensive care plan and care path for the patient / resident once admitted to the facility/program through the initial admission /evaluation process at which time all disciplines screen the patient for service needs and submit recommendations. The case manager assembles all recommendations into the initial care plan reviewing it with the physician and specialists as needed.

The Case manager also oversees the management of the discharge planning moving the patient / resident to the next level of services/care such as home with services or to assisted living (care continuum is circular with the patient at the center). All the while, the case manager is managing the benefit, planning the most appropriate use of services, directing patient teachings, monitoring drug utilization etc. to help the patient learn to care for himself and be ready to move to a more independent level of care. Thus she is not only a benefits manager, but also a customer/patient advocate (to help deliver better Customer Service) and teacher /or one who arranges for teaching to occur.

The care plan must be comprehensive and forward looking. It is a map of care for today and for the future. This means that all of the needs of the patient as s/he progresses through his/her healing / recovery processes are fully addressed, and s/he is educated about his/her healing / recovery process to motivate him/her to be an active partner in the return to wellness. The more educated the patient and family is, the more they support and enable the healing/recovery process to occur.

The pre-admission evaluation followed by the acute care discharge paperwork creates the initial patient admission snapshot from which the Health Care Center interim care plan is initially created. This is put into place upon admission to the Center. Following admission and within 48 hours the entire care team then screens the patient/resident for all services and therapies. This is information is then gathered to create the MDS/RAPS and the initial care conference is planned for day 5, or latest day 14. In the assessment process, the patient is assessed for all and any risks. These risks range from nutrition, weight loss/gain, mobility/ambulation/falls, to continence/incontinence etc. As the assessments are made, the interim care plan is developed with approaches built into it to address all identified risks. This Client pro-activity is a vital part of the case/care management process and involves all members of the care team. This also helps address the quality indicators and quality measures as well as the continuous quality improvement efforts of the Center.

Case mix is important to all health care providers. The acuity, payer mix, and levels of financial reimbursement all impact operating margins. The costs of each case are managed as well as are the reimbursement through the case management process. Without monitoring costs and the mix of cases and payers, margins could be severely negatively impacted at the Center.

Cost control mechanisms and tracking/monitoring are critical to cost management. These techniques vary from care planning and effective problem solving to determining the most appropriate drug use prior to discharge to grouping tests, and monitoring rehabilitation programs for efficiencies. Tracking cases, lengths of stay, overall outcomes and costs creates a base of knowledge that allows for the case manager/Center to better control costs and determine cost per case and over all cost of the programs. Cost control mechanisms built into case management are another part of the checks and balances that a well-established case management system affords a Center's operations. These mechanisms help ensure oversight, and, in the end, profits.

Compliance is an ever-increasing area of concern in the operation of Health Care Centers today. Case management offers yet another avenue through which regulatory compliance steps are built into the operation of the Center. Whether we are addressing concerns surrounding proper admission processes and forms from a HIPAA standpoint, or the Patient's Bill of Rights, or the Office of the Inspector General, all of these areas are also addressed through the case management processes. The monitoring/auditing function of the case manager creates the opportunity for additional oversight of compliance issues.

Case management also involves monitoring contracts for both vendor and payer. As the case manager is managing the care and monitoring the service delivery, s/he also is auditing the cost of the services against the contracted rates to ensure contract compliance and cost effective

service delivery. A similar scenario applies in regards to payment. When negotiated rates are in force the case management process ensures that the proper payment is received for care delivered at a set level/rate. This does not necessarily mean that the Center's case manager by her/himself is carrying out this function but it does mean that in conjunction with the billing office this payment auditing is performed ensuring proper payment is received.

Continuous quality improvement (CQI) is yet another of the Ten Cs of Case Management. As the leader of the care delivery for the cases managed by him/her, the Center's case manager has the responsibility and opportunity to play a role in the quality improvement initiatives of the Center. This opportunity exists as a result of the fact that the case manager is charged with maximizing the care quality and effectiveness of the care delivered for each case. This function also means then that s/he has the responsibility for recommending changes that would result in better or more effective care delivery. It is this observational and problem solving role that puts the case manager at the nexus of opportunity to impact the CQI process with its Quality Indicators and the Quality Measures. In addition, the buy-in of the Center's Medical Staff in the quality care delivery process / CQI is further facilitated through the case management quality of care auditing and problem solving activities.

As the resident / patient learns to take an active participatory role in his/her healing, the satisfaction levels with care and other services tends to rise as well. The case management approach is a Customer teaching / advocating approach that reaches out to and involves the patient from the initial pre-admission evaluation in an educational process. The case manager facilitates teaching of the resident educating him/her and advocating for him/her to control his individual healing process. The greater the involvement, the greater the levels of satisfaction with services and recovery is accomplished more quickly. A key step in the care delivery /patient educational process occurs when the patient's attitude shifts from letting others "do" for him and care for him to caring for himself. When the patient sees himself as directing his care and recovery with the case manager as his "Coach" to recovery, he has accomplished the most important step to recovery. He has taken ownership of his healing process.

In the role of Customer/resident/patient advocate the case manager acts on behalf of the patient to obtain the most appropriate services at the most appropriate time and location. This contributes to the overall effectiveness of the care/service delivery, the involvement of the patient and the satisfaction levels of the resident and family with the final outcome. This may require additional education of the physician, the payer, the resident and or the family for all parties to understand what is most appropriate at what time in the care plan optimizing the care delivery process.

In sum case managers play a pivotal role in leading and managing the recovery and healing for the cases in their care. They are the "Coach" and team leader, the advocate and quality and contract monitor. They assist the care team to pro-actively problem solve to deliver better, more effective and higher quality care. They are directing the collection of statistics to measure the outcomes of the care (length of stay etc.) while advocating for the best, most appropriate, and yet cost effective care. They assist the Finance office with getting proper payment and monitoring costs while monitoring the care plans for effectiveness and coordination. They are essential in monitoring compliance, case mix and in motivating both patient and staff. All leading up to the

realization that the patient / resident willingly will participate in his/her comprehensive care plan because he truly is the "Boss" of his recovery. He has control and his "Coach" is there to help him and advocates for him with the payer, physician, caregivers and other members of the team. This approach leads to higher levels of not only resident/family satisfaction, but also total customer/staff satisfaction including physicians, referral sources and others.

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