Effective Case Management Models: Which Should You Use?

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FACULTY

**Toni G. Cesta, Ph.D., RN, FAAN** is Partner and Health Care Consultant in Case Management Concepts, LLC, a consulting company which assists institutions in designing, implementing and evaluating acute care and community case management models, new documentation systems, and other strategies for improving care and reducing cost. The author of eight books, and a frequently sought after speaker, lecturer and consultant, Dr. Cesta is considered one of the primary thought leaders in the field of case management. Dr. Cesta writes a monthly column called “Case Management Insider” in the Hospital Case Management journal in which she shares insights and information on current issues and trends in case management. Prior to her current work as a case management consultant, Dr. Cesta was Senior Vice President – Operational Efficiency and Capacity Management at Lutheran Medical Center in Brooklyn, New York.

**Bev Cunningham, RN, MS** is Vice President, Resource Management at Medical City Dallas Hospital. Her areas of responsibility include Case Management, Health Information Management, Clinical Documentation Integrity, Patient Access and Transplant Financial Services. Bev is a well-known speaker in the Case Management field. Involved in the development of case management for over twenty five years, her areas of expertise include denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification. Bev is also a partner and consultant in Case Management Concepts, a company that provides support to hospitals regarding effective Case Management model development and evaluation. Bev's publications include a chapter in CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. She is also on the advisory board for Hospital Case Management.
1. Discuss the foundations of case management practice.
2. Review the critical functions of an effective case management department model.
3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
4. Evaluate case management protocols and penalties.
CASE MANAGEMENT STEERING COMMITTEE

They can help you by being allies in the change process!!!!

- Administration
- Nursing/Patient Care Services
- Physician Leadership
- Director of Case Management
- Director of Social Work
- Emergency Department Leadership
- Finance Leadership
- Patient Flow
- Others as needed
MODEL DESIGN

• Determine your case management model
• Review roles and functions of other members of the interdisciplinary care team
  • Social Work
  • Physicians
  • Staff Nurses (discharge planning, etc.)
  • Ancillary Services
• Interdisciplinary patient care rounds
• Case management clerical support
PICKING THE MODEL THAT WILL BE RIGHT FOR YOUR ORGANIZATION

COMPARISON OF TWO MODEL DESIGNS
INTEGRATED MODEL

ALL FUNCTIONS PERFORMED BY A SINGLE CASE MANAGER. INTEGRATES PREVIOUSLY DISCONNECTED FUNCTIONS.
DEPARTMENTAL FUNCTIONS in the INTEGRATED MODEL

Case Management Roles:

- Patient flow or coordination and facilitation of care
- Utilization management
- Discharge / Transitional planning
- Variance tracking
- Quality management
INTEGRATED MODEL

CASE MANAGER

SOCIAL WORKER

CORE MEASURES
CDI
A LOOK AT THE INTEGRATED MODEL – SHARING DISCHARGE PLANNING

NURSE CASE MANAGER – CLINICAL DISCHARGE PLANNING

SOCIAL WORKER – PSYCHOSOCIAL DISCHARGE PLANNING

DISCHARGE PLANNING SPECIALIST
GOALS OF ACCESS POINT CASE MANAGEMENT

• Manage and control the types of patients approved for admission
• Provide for alternative care when needed and appropriate
• Ensure hospital reimbursement
ADMITTING DEPARTMENT CASE MANAGEMENT

- Provides gatekeeping function for:
  - Planned admissions
  - Urgent admissions
  - Direct admissions
  - Transfers
EMERGENCY DEPT CASE MANAGER
ROLE FUNCTIONS:

1. Gatekeeping
2. Coordination / facilitation of care
3. Utilization / resource management
4. Transitional planning
DETERMINING CASELOADS IN THE INTEGRATED MODEL

- Best practice ratio for case manager to beds
  - Medicine / Surgery = 1:15
  - ICU = 1:20
  - Maternal Child / Pediatrics = 1:20
- Best practice ratio for social worker = 1:17 active cases

Toni Cesta, 2008
RATIOS

- Physician advisor = review 10 cases per day
- Documentation improvement specialist
  - 10 new charts per day
  - 15 existing charts per day

Toni Cesta, 2008
Collaborative Practice / Triad Model

Separates the clinical and “business” functions of case management into separate roles and partners actively with social work to achieve results.
DEPARTMENTAL STRUCTURE
COLLABORATIVE PRACTICE MODEL

Case Manager

Business Manager

Social Worker
Case Manager
- Risk Screening
- Assessment & Planning
- Coordination of Care
- Resource Utilization
- Outcome Management
DEPARTMENTAL STRUCTURE
COLLABORATIVE PRACTICE MODEL

Case Manager

Leveraged work vs.
routine tasks
Stewardship
Clinical focus
Service line orientation

Manager
Worker
DEPARTMENTAL STRUCTURE
COLLABORATIVE PRACTICE MODEL

Business Manager
Medical Necessity Screening
Authorization/Certification
Observation Status Compliance
Clinical Documentation Improvement
Denials Management

Case Manager
Social Worker
DEPARTMENTAL STRUCTURE
COLLABORATIVE PRACTICE MODEL

Business Manager
• Primarily works the “business” side of case management
• Intense review of documentation
• Liaison between team members and payers / regulatory entities
DEPARTMENTAL STRUCTURE
COLLABORATIVE PRACTICE MODEL

Social Worker
Screening
Assessment & Planning
Brief Therapeutic Intervention
Continuum of Care Planning
Crisis Intervention
Worker
Case Manager

Case Management
Screening
Assessment & Planning
Brief Therapeutic Intervention
Continuum of Care Planning
Crisis Intervention
Social Worker

• Allows focus on core social work issues vs. routine tasks
• Assist with discharge planning for select patients
• Clear criteria for SW referrals (substance abuse, legal, crisis, etc.)
STAFFING RATIOS IN THE COLLABORATIVE MODEL

- Case manager = 15 - 23
- Business specialist = 20 - 40
- Social worker = 1:17 (30 - 40 % of all patients are active cases)
Key Difference Between These Case Management Models

INTEGRATION OF UTILIZATION MANAGEMENT INTO THE CASE MANAGER ROLE VS. SEPARATE UM / DRG SPECIALIST ROLE
ADVANTAGES OF EACH MODEL

INTEGRATED MODEL
• Everything under one umbrella
• Reduced duplication, fragmentation and redundancy

COLLABORATIVE MODEL
• Consolidates business functions of case management into one role – builds expertise
• Case managers not consumed with routine payer functions
ADVANTAGES OF EACH MODEL

INTEGRATED MODEL
• Data collected once for multiple purposes
• Case manager in direct communication with third party payers, post-acute providers and vendors – they know the case!

COLLABORATIVE MODEL
• Case managers have time to focus on more leveraged functions
• Expanded focus on clinical documentation improvement and resource utilization
ADVANTAGES OF EACH MODEL

INTEGRATED MODEL
- One stop shopping
- May be more cost-effective... may require less staff
- Physician and other staff only have to communicate with one person on all case management issues

COLLABORATIVE MODEL
- Separates two time dependent functions
- Decreases competing priorities and worker frustration
- Creates holistic jobs that optimize skills and talents of different disciplines
DIS-ADVANTAGES OF EACH MODEL

INTEGRATED MODEL
- Bundles highly time-dependent functions (discharge planning and utilization review) – can be frustrating for staff to manage
- If not done well can morph into ‘task-y’ model in which DP + UR = CM

COLLABORATIVE MODEL
- Requires intensive communication between triad members (for example: run the list)
- Creates some duplication such as
  - Business manager and case manager both reviewing chart
  - Assessing patient
DIS-ADVANTAGES OF EACH MODEL

INTEGRATED MODEL
• Detail work of utilization review may appeal to some staff more than other aspects of case management
• Will not work if staffing is not adequate (entire infrastructure will crumble)

COLLABORATIVE MODEL
• Works best if all disciplines report to same administrator
• *May be more costly and require more staff*
• Will not work if staffing is not adequate
HOW ARE THESE CASE MANAGEMENT MODELS ALIKE?

THEY BUILD ON THE INTER-RELATIONSHIP OF DISCIPLINES TO ENHANCE CASE MANAGEMENT OUTCOMES

THEY REQUIRE STRONG SOCIAL WORK INVOLVEMENT
HOW ARE THESE CASE MANAGEMENT MODELS ALIKE?

TO BE SUCCESSFUL BOTH THESE MODELS REQUIRE:

- ADEQUATE STAFFING
- BALANCED WORKLOAD
- SKILLED STAFF
- STRONG LEADERSHIP
ROLES, FUNCTIONS AND CASELOADS ARE INTERRELATED

The more role functions you give a hospital case manager, the fewer patients she can handle.

Obvious?? Maybe............
ADDITIONAL ROLES TO ENHANCE THE EFFICIENCY OF THE DEPARTMENT
• Manages the most complex discharge planning issues
• Allows the staff to manage more routine patients
• Interfaces with legal, guardianship, undocumented, uninsured issues
• Identifies high risk patients with frequent admissions / readmissions / emergency department visits
• Assesses causes of readmissions
• Interfaces with community agencies and primary care physicians
• Works with community case manager if available
• Reviews records for clarity and completeness of documentation
• Interfaces with physicians, NPs and PAs when additional documentation is needed
• Works with case manager to ensure that clinical documentation matches the level of care ordered
• Can also identify missing core measure documentation
DESIGN ELEMENTS IMPACTING CASE LOADS

Model Design
- Integrated vs. collaborative
- Other

Roles and Functions
- Coordination / facilitation of care
- Utilization and resource management
- Discharge and transitional planning
- Variance identification
- Quality management
- Clinical documentation improvement
CAUTION: WORKLOAD AND CASE LOAD MUST BALANCE

Increased workload = Decreased caseload
PATIENT ASSIGNMENT MODELS

- UNIT-BASED
- DISEASE BASED
- PRODUCT LINE
- PHYSICIAN ALIGNED
- HIGH-RISK CRITERIA
  - PAYER
  - COMPLEXITY
  - LOS/COST
  - CLINICAL
- HYBRID
PAYER MIX

- Check your third party payer split
- More managed care = more reviews
- More Medicare = more complex discharge planning
- More Medicaid = more psychosocial issues
INTENSITY OF SERVICE

- What kind of services do you provide?
- Are you a community hospital or a tertiary hospital?
- Do you transfer patients in or out?
- Does intensity of service effect coordination of care and length of
Define complexity for your patient population?
- Medical / Surgical
- Psychosocial
- Financial
LENGTH OF STAY

• This can be a double-edged sword
• Shorter length of stay = faster turnover
• Longer length of stay = more complex discharge planning
USE OF TECHNOLOGY

Case management software can make your department more efficient by eliminating clerical type paperwork
- Census reports
- Daily assignments
- Retrospective data entry
- Faxing/Xeroxing

THIS WILL FREE PROFESSIONAL STAFF UP TO SPEND MORE TIME WITH PATIENTS!
STAFFING ANALYSIS PROCESS

- Start with the baseline staffing ratios based on your model
- Use the indicators presented to determine whether you need to increase or decrease the baseline
- Remember to consider the clinical areas you are staffing as each may have unique needs
- Revisit staffing ratios annually
KEEP FLEXING

- Re-evaluate
- Be open to needed changes as you move forward, nothing is in stone
- Bring issues back to steering committee
- Make changes as needed
- Be flexible
AND REMEMBER

“FAILING TO PLAN IS PLANNING TO FAIL”
(Fortune Cookie)
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THANKS!

Bev and Toni