THE CENTER FOR CASE MANAGEMENT

New Definition

Karen Zander RN, MS, CMAC, FAAN: Editor

Spring/Summer 2009
Vol. 24 No. 1
ONLINE EDITION

The Six Core Functions of Case Management Services

Introduction

Case Management services continue to evolve as they touch almost every operation in the hospital and move into the center of the decision-making around and with each patient and family. In many ways, case management as an overall process of connecting resources to needs has not substantially changed over the last 200 years; only the applications have expanded — from primarily social welfare concerns to combinations of concerns including health, laws, policy, and finances.

Case management is the scientific method (assess, plan, intervene, evaluate/improve) applied with individual patients and families using lateral leadership with the healthcare team to ensure clinical integration, necessary to accomplish key clinical, financial, and satisfaction outcomes, as far across time and place as the patient and organization gives authority to do so. Case management is a process, a role, a system, and a strategy.[1] Although this article addresses the core functions of case management in acute care hospitals, some of or all 6 core functions described here are evident in non-acute care settings as well as in the insurance industry. These distinct but overlapping functions are listed below and shown in relation to each other in Figure A[2]:

- Access/Liaison
- Utilization Review/Management/Documentation Improvement (CDI)
- Care Coordination and Interventions
- Discharge/Transition Planning and Execution
- 30-day Post-Recovery Period
- Prevention and Disease Mgmt.

1. **Access/Liaison Function:** The emphasis of Access and Liaison is on facilitating the entry of patients into specific levels of care and access to community services. Transfer Centers, through which all patients from all sources are screened, are the newest component to Access. Access can also include liaison bed placement, registration, pre-authorization and pre-certification screening, as well as assessments by liaison personnel from post-acute agencies. It might also include booking appointments and transportation arrangements. Tools include electronic Bed Boards, insurance verification and medical necessity software. Methods include clerical functions and connections with the business office, availability of liaison personnel onsite to evaluate potential referrals, ambulance and van contracts, and centralized bed placement within a health system.
2. **Utilization Review/Utilization Management/CDI:** The emphasis of Utilization Review and Management, as well as Clinical Documentation Improvement (CDI), is on reviewing or auditing patients using criteria that demonstrate medical necessity to

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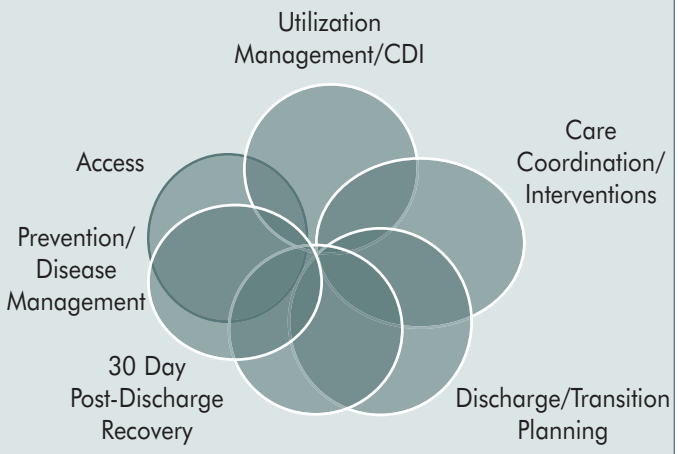
1 Bower, K. The Center for Case Management

2 Formerly shown as The Evolving Core of Case Management; revised 2009 by T. McCright.

achieve reimbursement and prevent denials (from Medicare's Retrospective Audit Contractors and other payers) for the services delivered. This function may also include auditing Avoidable Days and Quality Indicators. Tools may be automated, and include standardized criteria for medical necessity and avoidable day documentation. Tools also include prompters for core measures, standardized order sheets, faxes and phones. Methods include discussions with physicians, negotiations with payers, and referrals to a Physician Advisor as needed. A Clinical Documentation Improvement Specialist is a nurse that specializes in detailed medical record review, usually concurrently to the patient's hospital stay, to assure that the physician documentation accurately reflects the patient's entire condition, co-morbidities and complications, before submission to payers. Methods include concurrent and retrospective auditing, querying, educating, and analysis.

3. **Care Coordination/Care Intervention:** The emphasis of Care Coordination is on positive partnerships with nursing, physicians, and other key disciplines in order to pace the care toward outcomes while incorporating best practices within the appropriate level of care. Targets of the Care Coordination function are lower LOS (thus additional capacity), lower cost per case via lower resource utilization, and strategic clinical interventions that resolve symptoms as well as remove barriers to discharge/transfer. Care Coordination and Intervention is needed between the admission and the discharge or transfer. Although physicians and nurses have traditionally provided this function, case managers are taking more of a leadership role to decrease the increasing fragmentation in continuity of care. Tools include clinical paths, treatment plans, care plans, order sets, progress notes, and CareGraphs™.[3] Methods include team meetings, family meetings, Care Coordination Rounds and Complex Care Rounds.
4. **Discharge/Transition Planning:** The evaluation of needs requiring discharge planning is a legally-mandated function including collaboratively determining level of care needs beyond acute care, providing decision support to patients and families and MDs, managing patient and family expectations, and ensuring a smooth transition to the next level of care and services. Discharge and Transition Planning are non-linear activities; i.e. they involve a complex, interwoven set of tasks and responsibilities that may be completed by one or more people from one or more professions. Tools to manage this function include discharge planning software, care management software with desired clinical outcomes identified, checklists, and detailed assessments with action plans and evaluations of outcomes. Methods include family meetings, use of liaison personnel to meet with potential referrals, transition to hospice, homecare, palliative care, skilled nursing facilities, etc.
5. **Post-acute Recovery Period:** The Recovery Period is considered the first 30 days following an acute care hospitalization, although it often takes much longer to completely recover from whatever factors caused the hospitalization. DRGs essentially amputated this phase of illness from the acute care setting, requiring increased use of post-acute agencies. As a result, the 30 days are a very risky period in which complications and exacerbations may occur due to the original reason for hospitalization, the hospitalization itself, or related problems as patients are recovering. Unless the patient goes to another level of care that provides nursing monitoring, this is an extremely unmanaged period of time. Tools and methods to manage the recovery period include patient/ family education materials, structured and timely phone calls to patients, making appointments with primary care physicians, and visits by recovery specialists/coaches, etc.
6. **Prevention/Disease Management:** Disease management consists of a group of coherent interventions designed to prevent or manage one or more chronic conditions using a systematic, multidisciplinary approach and potentially employing multiple treatment modalities[4]. Disease management interventions might be coordinated by any discipline in health care. Tools include educational tools, the internet, diaries, etc. Methods include scheduled meetings, classes, appointments, phone calls, group support.

FIGURE A
Best Practice Components of Case Management



Examples of Combined Functions

As shown in Figure A, each function can lead into or overlap with the nearest related function. The large variation in roles and models within acute care hospitals is an acknowledgement of the close connectivity between functions. The three role descriptions below demonstrate how difficult pigeon-holing case management definitions and roles can be.

1. *Clinical Social Work:* A master's-prepared (MSW) clinical social worker provides skilled interventions for a) the support and/or resolution of patient and family crises, b) problem-solving and decisions, c) advocacy and facilitation necessitated by live-changing events (adoption, guardianship, abuse, placement, bereavement),

3 See *www.cfcm./newsletterarchives*; Fall, 2005 for CareGraph™ Clinical Progressions

4 Schrijvers, G. (2009) Disease management: a proposal for a new definition; International Journal of Integrated Care; Jan-March Vol 9 (6). Retrieved from *www.pubmedcentral.nib.gov* , June 15, 2009.

d) mediation of risk factors and coping with disease or disability, and e) other psychosocial and/or socio-economic issues. The role may include other functions, such as discharge planning, although these should not constitute the majority of the clinical social worker's functions. Tools include detailed assessments and progress notes, community resources and references. Methods include crisis intervention, advocacy, family and team meetings, referrals.

2. *Case Manager with Integrated Functions:* An case management professional, usually an RN, who has 3 main functions to provide daily in a timely and integrated workflow: 1) UR, 2) Care Coordination, and 3) determination of Plan A and B for the next level of care. Tools and methods include all those listed above under each separate function. In this role, fluid reprioritization and time management skills are critical for effectiveness.
3. *Emergency Department Case Manager:* A case management professional, usually an RN, that assists the patient, ED staff, and the hospital in 1) determining the accurate level of care between Observation and Inpatient, 2) discharge planning directly from the ED, 3) initiating plans of care, and 4) developing and implementing a case management plan for frequent patient visitors to the ED. Tools include criteria for medical necessity, community resources and references. Methods include the use of criteria, negotiation, and creative problem-solving.

What function(s) does this patient and family need from our team today??

Although defining each function and building models that include all of them is important to the success of case management services, *the central question for every case management professional every day is to determine what function or functions each individual patient and family require from the team of professionals (leadership of the team being the nurses and social workers)*. For example, one patient may need to apply for Medicaid (UR function) while waiting for a placement (DP function). Another patient may need to be converted from OBS status to inpatient (UR function) as he becomes critically ill, while his family needs to make rapid decisions about his treatment (Care Coordination/Intervention function).

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There are a few basic activities that must occur to address the central question above. These activities should be considered standards of a case management service, regardless of the model.

1. Huddles and rounds are opportunities to discuss these needs among the team and organize to address them.
2. In-person, face-to-face direct assessment of patients and families upon admission is fundamental to really knowing them as individuals and leads to accuracy in all the subsequent functions.
3. Daily review of level of care is fundamental to coordinating their care, not just to UR. Care Coordination fills that 3-4 days between admission and discharge with attention to best practices and collaboration with physicians, therapists, and other specialists as the team learns exactly what the revised needs for transitions will be.
4. Teams that wait for discharge orders before working with patients and families will be in crisis mode. As CMS begins to clamp down on payments for readmissions within 30 days[5], our understanding of causes and solutions to inaccurate discharge/transition planning will become clear. Future issues of New Definition will address these challenges.

5 CMS 9th Statement of Work