Coordination of Care

Acute Care Case Management

Acute Care Nurse Navigation, Discharge Planning & Utilization Management
Objectives

- Discuss “referral triggers” for a Case Management referral
- Discuss types of services that Coordination of Care provides
- Discuss Utilization Management Functions
Who is Coordination Of Care?

- Coordination of Care is a department comprised of Case Managers with backgrounds in Nursing and Social Work that assess the patient’s medical necessity for admission, acute care needs upon admission, plan for the patient’s safe throughput in the acute care setting, and implement a safe transition to a lower level of care.
Case Management Assignments

- Case Managers are assigned to the Emergency Room as well as specific nursing units for continuity of care.
- The Emergency Room Case Managers have an RN to perform Utilization Management functions and a SW to handle social issues.
- Most Case Managers have offices centrally located on their assigned units.
- Most nursing units have both an Acute RN Nurse Navigator and a Medical Social Worker who collaborate to facilitate safe and timely discharges.
- Each Case Manager has a cellular phone for ease of accessibility.
- Weekend and Holiday coverage is provided with reduced staffing.
- There is a Utilization Management Team of RNs that perform Utilization Management functions.
**Acute Care Nurse Navigator (ACNN)**

- The function of the ACNN is to help the patient and family navigate the very complex healthcare delivery system, both during the acute care stay and also in transition back to the ambulatory setting.
- The ACNN is the key informational support liaison for the patient and family from the treatment team.
- The ACNN is a key resource for nursing supervision and clinical operation in identifying areas for process/performance improvement that adversely effects timeliness.
- The ACNN screens all patients that are readmitted within a 30-day timeframe and develops an effective transitional plan to help reduce the risk of readmission for future visits.
- The ACNN works collaboratively with the Medical Social Worker to implement an effective and timely transitional plan for the patient.
Medical Social Worker

- The function of the Medical Social Worker is to facilitate discharge planning activities on the units.
- The Medical Social Worker identifies complex patients and provides psychosocial assessments, crisis intervention, discharge planning and coordination of referrals and resource information to patients and families in need of assistance.
- The Medical Social Worker works in collaboration with the Acute Care Nurse Navigator to prevent delays and barriers to care delivery.
- The Medical Social Worker provides an array of social work services to patients and families to promote understanding and resolution of problems related to environmental stress, physical illness, interpersonal conflicts, and other psychosocial issues.
Case Management: Keys to Success

- Early application of Interqual criteria to establish medical necessity for admission or readiness for discharge
- Early identification and discussion of plan of care with physician, attending nurse, patient, and family/caregiver
- The case manager evaluates daily the patient’s progress to determine the anticipated date of discharge and identifies and makes arrangements for post discharge needs while anticipating the outcomes of that transition
Definition of Case Management

- Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

CMSA
Role of the Case Manager

- Advocate
- Assessor
- Planner
- Coordinator
- Facilitator
- Educator
- Broker
Referral Triggers for Case Management

- Involuntary Commitments: Hotline 615-6987
- VMA (Valley Medical Associate) patients
- VA Medical Center patients
- Recent readmission within 30 days
- Disease specific diagnosis- CHF, AMI, Pneumonia, Total Hip & Knee Replacements, Sepsis, Failure to thrive
- Currently receiving Home Health/Hospice services
- Placements: Nursing Home, Rest Home, Group Home
- Inadequate support system/Unsafe home situation
- Complex family issues/family conflict
Referral Triggers for Case Management

- Critically ill with no/limited family support
- Terminally ill/poor prognosis
- Lack of Capacity to make decisions/Guardianship issues
- Abuse/Neglect/DSS referrals
- Homeless
- Self-pay/Complex financial issues/Inability to obtain prescription medications
- Transportation needs
- Substance Abuse
- Need for community resources
- Grief counseling
How does Coordination of Care receive referrals?

- Via admission assessment screen in ValleyLink per admitting nurse
- Via daily nursing notes in ValleyLink
- Physician order
- Patient or family request
- Request from nursing or ancillary staff such as physical therapy, occupational therapy, speech therapy, respiratory therapy, or dietician
- Per case managers review of the chart/initial discharge planning screening process
What does Coordination Of Care do daily?

- Daily interdisciplinary rounds with staff nurse, VMA physician, Lead Charge RN, and PCM when available
- Assigns patient’s anticipated date of discharge (ADOD)
- Updates ADOD as clinical condition changes per physicians recommendation
- Reviews patient’s clinical readiness for discharge with the physician
- Plans ahead for discharges within 24, 48, and 72 hours
What does Coordination Of Care do daily?

- Assists patient/family in making self-directed healthcare choices and decisions
- Documents plan of care and patient choices for post acute care services
- Facilitates communication among the interdisciplinary staff
- Coordinates safe and timely discharges of patients
- Specializes in complex discharge planning
- Utilization Review activities
Types of Discharge Planning Services

- Home Health
- Hospice
- Home Infusion
- Durable Medical Equipment
- Inpatient Rehabilitation/Subacute Rehabilitation
- Skilled Nursing Home Placement
- Long Term Acute Care Transfers
- Medication Assistance
- Department of Social Service Referrals
- Substance abuse/Family counseling
- Homeless Shelter Assistance
- Involuntary Commitments
- VA Facility Transfers
- VMA follow-up Appointments for Unassigned patients
Utilization Management 
Efforts

- Patients are screened upon admission either in the Emergency Room or retrospectively within 24 hours of admission by the UM Case Manager using Interqual criteria to establish if patient meets medical necessity (severity of illness and intensity of services) for admission.
- Patients who do not meet the screening criteria are referred to a Physician Advisor for review.
- All observation patients are screened for appropriate status determination for observation or admission and those that do not meet are referred to a Physician Advisor for review.
- Patients who are in observation status are reviewed daily to determine continued appropriateness for observation, admission or for discharge.
Utilization Management

- Interqual Criteria Sets
  - Applied to all patients upon admission for appropriate status assignment
- Medicare/Medicaid Regulatory Function
- Initial Admission Review
- Concurrent Review
- Retrospective Review

- Insurance reviews
  - Private Insurances
  - Initial and Concurrent Reviews
  - Denial Management
Performance Improvement Efforts

- Quality of Care Indicators
- Length Of Stay
- Case Mix Index
- Facilitate discharges before 1100
- Readmissions within 7 days, 30 days
- Delays in care- Avoidable days
- Cost savings- Saved days
- MD scorecards
Continuum of Care

Medication Needs upon d/c

Quality of Care

Anticipated Date of Discharge

Safety Emotional Functional Needs on d/c

Utilization Management Interqual Criteria Admission, Observation, or Outpatient Status determinations Private Insurance Reviews

Appropriate care in the Appropriate setting

Choice of post acute Service

Skilled nursing home placement Home health/Hospice Assistive devices

Patient Discharge Plan
Where is Coordination Of Care located?

- Coordination of Care is located in the West Wing Basement. From the front lobby of the hospital, bear right, take the first hallway on the left, follow this hallway until you reach the elevators on the right. (Security, Mailroom, and the Morgue are also located on this hallway). Enter the elevator and press “B” for basement. Enter COC through the double grey doors. The Department Secretary will greet you at the front desk.
Contact number for Coordination Of Care

615-6835
Questions?