As a utilization review nurse in the psych unit of Fulton County Health Center in Wauseon, OH, Tina Leach, RN, CCM, regularly sees the problems a lack of integrated care management can cause on a hospital floor. “You see patients who don’t take their meds, you see readmissions, you see patients getting sicker and sicker. It’s a real problem,” says Leach.

Although Leach admits the need she sees for integrated case management is amplified in the psych unit, the former ED nurse says the need is pervasive and affects each unit of the hospital.

And the pressure is on for case managers to reduce readmissions and prolonged LOS, which may be caused by a lack of integrated care management.

“Ohio Medicaid is looking a lot now at readmissions. Fifteen years ago, that wasn’t the hospital’s problem, but now we’re looking at denials … I expect issues with Medicare reimbursement will come around too,” Leach says.

Why integrated case management?

For the past two years, independent hospital case manager Becky Perez, RN, CCM, CPUR, CPUM, and Roger Kathol, MD, adjunct professor of internal medicine and psychiatry at the University of Minnesota, both of Cartesian Solutions, Inc., in Burnsville, MN, have studied the benefits of an integrated case management program.

According to their study, 5% of patients are complex and use half or more of a facility’s healthcare resources. More than two-thirds of this small group has concurrent physical and mental health/substance use disorders, yet a lack of communication about clinical assessments and treatment can result in an upsurge of issues.

“Interaction is limited … this disintegrated care leads to poor clinical outcomes, high total healthcare costs, and reduced productivity,” says Kathol.

According to the study, an integrated case management solution can save a typical hospital an average of
Patient care < continued from p. 1

115 days and $2.9 million over a two-year period. “When a patient falls through the cracks, you look at prolonged length of stay, inappropriate discharge planning, and re-admissions,” says Kathol.

Perez and Kathol have created a relationship-based evaluation tool (see p. 3) that assesses the complexity of each patient. “By identifying four domains, we hope to identify barriers to improvement. How a patient is scored will lead to action by the case manager, and a care plan will develop from documentation in this grid,” says Kathol.

Integrated training allows case managers to proactively help hospitalized patients by increasing their ability to:

- Flag and interview high-risk patients for complexity during admission evaluations
- Link multidomain (e.g., biological, psychological, social, and health system) barriers to improvement with specific management activities
- Reduce the occurrence of adverse hospital events and shorten LOS
- Prepare complicated patients for discharge
- Improve access to complexity-based postdischarge community services

Leach says this type of approach is extremely important when reducing readmissions.

“With mentally ill and, especially, chronic mentally ill patients, you need to start their plan of care with an understanding of their issues,” she says. “Follow-up is important: Do they have issues with staying on their meds? Do they have issues at home? When you let one issue fall through the cracks, you see it multiply as a problem.”

Addressing the issues

Integrated health management requires a willingness to look at the whole patient—not just the physical illness—and the ability to communicate with a patient in a manner that is not judgmental, says Perez. She explains that hospital case managers can play a key role in exploring with the patient what barriers are preventing a better health status.

“When caring for patients that have multiple comorbidities, there is likely a behavioral aspect that complicates a physical condition,” Perez says. “When patients experience multiple ER visits, admissions, or physician visits, their condition is not well managed.”

Perez suggests hospital case managers build a foundation for care by examining with patients why their health is not optimal. This can be accomplished by asking open-ended questions, such as:

- How do you view your health and the role you play in your own well-being?
- What are the major barriers for you in caring for your own health?
- Do you take your medications as prescribed?
- Do you understand why you are expected to take the medications as prescribed?
- Do you have any financial constraints or worries?
- How is your home life?
Do you have any psychosocial needs that should be addressed (e.g., do you feel sad or anxious)? Hospital case managers can obtain a baseline for the integrated care management plan and, by assessing the patient’s additional needs, make referrals to the appropriate providers and inform existing providers of what is needed to better manage the patient’s illnesses and behaviors.

“When you address all of a patient’s needs and realize how one affects the other, that is when you have a truly integrated process,” says Perez.

### Integrated case management scoring sheet

<table>
<thead>
<tr>
<th>Domain</th>
<th>Historical</th>
<th>Current state</th>
<th>Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>Score</td>
<td>Score</td>
<td>Score</td>
</tr>
<tr>
<td>Biological</td>
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<td></td>
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<tr>
<td>Chronicity (HB1)</td>
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<td></td>
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<tr>
<td>Diagnostic dilemma</td>
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<tr>
<td>Diagnostic/therapeutic challenge (CB1)</td>
<td></td>
<td></td>
<td>Complications and life threat (VB)</td>
</tr>
<tr>
<td>Diagnostic/therapeutic challenge (CB2)</td>
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<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Barriers to coping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric dysfunction (HP2)</td>
<td></td>
<td></td>
<td>Mental health threat (VP)</td>
</tr>
<tr>
<td>Psychiatric symptoms (CP2)</td>
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<tr>
<td>Social</td>
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<tr>
<td>Job and leisure problems (HS1)</td>
<td></td>
<td></td>
<td>Social vulnerability (VS)</td>
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<tr>
<td>Social dysfunction</td>
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<tr>
<td>Access to care (HHS1)</td>
<td></td>
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</tr>
<tr>
<td>Treatment experience (HHS2)</td>
<td></td>
<td></td>
<td>Health system impediments (VHS)</td>
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<tr>
<td>Health system</td>
<td></td>
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<tr>
<td>Access to care</td>
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<td></td>
</tr>
<tr>
<td>Treatment experience</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Comments**: Enter pertinent information about each consideration for use as a part of interventions (e.g., poor patient adherence, death in family with stress to patient, non-evidence-based treatment of migraine):

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**Scoring**: 0 = no vulnerability or need to act; 1 = mild vulnerability and need for monitoring or prevention; 2 = moderate vulnerability and need for action or development of intervention plan; 3 = severe vulnerability and need for immediate action or intervention plan.

**Complexity assessment grid cells**: HB1—historical: physical health chronicity; HB2—historical: physical health diagnostic dilemma; CB1—current: physical health symptom severity/impairment; CB2—current: physical health diagnostic challenge; VB—risk of physical complications and life threat; HP1—historical: psychological barriers to coping; HP2—historical: psychiatric dysfunction; CP1—current: resistance to treatment/nonadherence; CP2—current: psychiatric symptom severity; VP—risk of persistent personal barriers or poor mental healthcare; HS1—historical: social, job, and leisure problems; HS2—historical: relational dysfunction; CS1—current: residential instability; CS2—current: poor social support system; VS—risk for additional home support or supervision needs; HHS1—historical: health system–related access to appropriate care; HHS2—historical: poor treatment experience; CHS1—current: ability to and ease of getting needed services; CHS2—current: logistical challenge in getting coordinated care; VHS—risk of persistent poor access to and/or coordination of services by providers and/or locations.

The RAC is back! How can I prepare my facility?

by June Stark, RN, BSN, MEd

Those in California, Florida, New York, South Carolina, and Massachusetts who were involved with CMS’ Recovery Audit Contractor (RAC) demonstration project can say, “The RAC is back!” For all others, the permanent RAC program is on the horizon, making this the right time for RAC readiness for case management departments throughout the country.

A Medicare initiative, the RAC’s goals are to recover and reduce improper Medicare over- and underpayments and improve CMS’ claims error rate.

The RAC demonstration project reported some astounding results, repaying $37 million to providers and having only 6.8% of RAC denials overturned by appeal as of June 30, 2008. Case managers should take these results seriously, but also know that:

➤ Appeals are still being processed
➤ Medical necessity has proven to be a strong argument for the overturn of denials
➤ Informal data from several Boston teaching hospitals have reported a 90%–100% overturn of denials for medical necessity

This should encourage case managers to participate actively in the RAC appeals process and confidently support medically necessary decisions made for prior cases, especially when using standardized clinical leveling criteria to build a strong appeal.

Improve your medical necessity knowledge base

The RAC project has made it necessary for case managers to become as knowledgeable as possible about denials and appeals. What do you need to do to be prepared for the RAC in your state? Here is a checklist to help you:

➤ Form a RAC committee in your facility. Include a medical advisor and representatives from finance, compliance, billing, and admitting. This committee should be a clearinghouse and review center for all RAC-related activities, including preparing for audits and understanding and determining vulnerabilities.

➤ Perform an internal audit of improper payments. Use findings from the RAC demonstration to help you prepare and identify the areas of vulnerability in your facility by visiting www.cms.hhs.gov/rac.

➤ Conduct a medical records audit of short stays. Examining your one- to two-day stays will help you gain an understanding of prior and present cases, as will the use of standardized clinical leveling criteria to establish the medical necessity of each case.

➤ Purchase and become an expert in a clinical leveling criteria tool, such as InterQual or Milliman. Learn the nuances of the tool by holding an on-site classroom session and networking with other case management experts. The key to averting or repealing denials is knowing the nuances of the criteria, so learn this tool and criteria well.

➤ Establish a system for checking the status of a medical record as well as the status of the audit process. Build or purchase a denials tracking system, which also helps determine trends in denied claims.

➤ Be confident during the appeals process. Do whatever it takes to be confident when appealing and stand by the presenting severity of illness and acuity of each case, no matter what the LOS. If you think you made the right choice for a patient, defend it.

➤ Identify a point person. Let your RAC know your precise mailing address and the contact person who should receive all RAC communications. That person must be prompt when responding to RAC requests.

➤ Participate in or form a statewide network of case management leaders. This will help you consolidate RAC learning opportunities, identify effective strategies, and establish a support group. The goal is to learn from each other.
Determining accurate caseloads

When case management caseloads become unmanageable, mistakes inevitably occur, which, in the age of audits, denials, and increased scrutiny of everything from medical necessity to correct level-of-care decisions, worries many facilities.

“You really try to strike the balance. You must be fiscally responsible when staffing, but sometimes that can come at a cost,” says Leah Montoya, RN, BSN, ACM, manager of care management at Advocate Good Shepherd Hospital in Barrington, IL. “When you have mistakes, audits, denials, you’re not saving money anymore and you’re compromising patient care.”

For years, case managers from a variety of health and behavioral health settings have complained of inconsistent and inappropriate case management caseload sizes. But rapid changes in the medical management field—such as the integration of utilization and disease management into case management functions—have made it difficult to provide equitable benchmarks for caseload determination.

Garry Carneal, JD, MA, president and CEO of Schooner Healthcare Services, LLC, in Annapolis, MD, and former president and CEO of the Utilization Review Accreditation Commission (URAC) in Washington, DC, says his time with URAC allowed him to see firsthand the frustration that oversized caseloads can cause case managers.

“It was obvious to me that a lot of case managers were getting frustrated,” says Carneal. “The larger caseloads are a byproduct of the integration of the case management system, where suddenly case managers are responsible for utilization management, disease management, and complex care management.”

Carneal explains that as the responsibilities of case managers have expanded, their workload has increased, but staffing has remained static at many facilities across the country. He has spent the past two years developing a caseload calculation matrix in conjunction with the Case Management Association of America (CMSA) and the National Association of Social Work, which can be found at www.cmsa.org. Through his work with URAC, Carneal says he witnessed frustration among case managers, who felt overwhelmed by their workloads, and patients, who were disappointed in the care they received.

Caseloads by the numbers

Although Carneal admits there are no consistent or supportive data to create a reliable equation for determining caseloads, there are four considerations facilities should analyze when determining case size:

➤ Initial elements affecting caseloads. Consider your target population and demographics, for example. If you cater to an indigent or elderly population, it will require much more of your case managers’ time and resources. Also, take into account the skill level of your case managers, the maturity of your program, and whether you have support services, such as technology support and evidence-based clinical applications, that can help case managers’ work go more smoothly.

“Some may think the solution is to add more case managers, but in some cases, a better investment would be in technology to help move things along in a more organized and cohesive fashion,” says Carneal.

➤ Comprehensive needs assessment. This includes clinical factors (symptoms, demographics, diagnosis, impairments) and psychosocial factors. “High-risk patients are always going to require more of a case manager,” says Carneal. “Look at the time these cases need and determine if your expectations are realistic.”

➤ Case management intervention. What goals have you have agreed upon with your multidisciplinary team and with patients, who should be the center of the team? “I wouldn’t recommend a facility say, ‘Each case manager has 20 patients.’ Caseloads should be under continuous review and should vary depending on the patients and the requirements of the caseload at hand,” says Carneal.

> continued on p. 6
Caseloads < continued from p. 5

➤ Intended outcomes. What are they and how can they be achieved by case managers with the caseload they’ve been assigned? “Some things to focus on are improved client health–related behaviors, changes in adherence, and a safe transition of care,” says Carneal.

Adding it all up

After analyzing these considerations, Carneal recommends evaluating your case management model to determine whether it fits with your caseloads.

“I wish I could say there were elements to plug into a calculator and suddenly you’d have the perfect number, but there isn’t. The variables are overwhelming,” he says.

It’s important to build a strong argument for appropriate caseloads when approaching hospital management, says Cheri Lattimer, RN, BSN, executive director of CMSA, adding that accurate caseloads can improve LOS, minimize avoidable days, and avert denials.

“There needs to be adequate time for appropriate discharge planning, patient-family education, and medication reconciliation, among other things. You have to look at all of these aspects when determining caseload,” Lattimer says.

Carneal and Lattimer recommend that when you approach hospital management with an argument for smaller caseloads, come armed with the following:

➤ A comprehensive list of elements that can affect potential caseload determinations in your case management setting (e.g., the acuity or the psychosocial needs of patients)
➤ Identified elements that can help you evaluate factors that may affect caseloads at your facility (e.g., is your facility in an area that has seen a spike in ED admissions?)
➤ Rationale for how the professional case management practice at your facility will be enhanced with more appropriate caseloads, thereby promoting quality care outcomes

“You have to come prepared with an argument of how you will save money in the long run. That’s not something we want to admit, but it’s the truth. So go in prepared,” says Lattimer.

The final equation

Montoya says her facility currently assigns 12–18 patients to each case manager. She agrees that being flexible is paramount to ensuring maximum return on investment of case management resources, as well as patient satisfaction.

“We review the caseloads regularly,” Montoya says. “If one case manager is particularly good with a difficult population, you shouldn’t compromise the care of the patient for the sake of numbers. Give that case manager 12 cases and give another one, who excels with a different population, 18. The balance isn’t necessarily in the numbers.”

Montoya’s equation appears to work for case managers. She says her case management department experiences very low turnover.

“We have a wait list to get into our case management department,” Montoya says. “They see and own the value of the department. They see the difference between a task-focused and a process-focused role, and I think appropriate caseloads go hand in hand with that.”

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Case management’s role in managing denials

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Identify methods for understanding basic individual payer utilization review rules and contract management
- Describe how case management can assist in the avoidance of denials

by Susan Fucito, RN, BSN, CCM, CPAR

With the economy in a downturn, most people are focusing on cost-saving efforts, and that goes for providers and payers alike. This is why a comprehensive understanding of hospital denials and their root causes will not only avoid front-end denials, but will also bring in revenue that may have gone unrecognized or been determined unrecoverable.

Case managers most often find themselves involved in denials related to medical necessity, avoidable delays, level of care, and assessment of LOS. However, denials that originate from other areas of the revenue cycle—such as inappropriate scheduling, authorizations, charge capture, coding, and back-end denial management—can significantly affect a hospital’s bottom line. Case management’s understanding of the basics of billing and payer reimbursement is key to a successful denials management program. With millions at stake, it is essential that case managers have knowledge and input in all aspects of denials management.

Understanding payer methodologies

To effectively avert and overturn denials, it is imperative that case managers have a firm understanding of payer methodologies. Payer methodologies in reimbursements and denials can vary considerably, but case managers should have a clear comprehension of a payer’s expectations up front so they can build a strong case for medical necessity based on payer expectations.

To understand denials management, case managers should first understand basic individual payer utilization review (UR) rules and contract management. The best way to do this is to review UR payer and provider contracts, which are easily obtained from payers and providers. Case managers should review these to build an understanding of payer rules regarding status, billing, denials, and appeals.

For example, different payers such as workers’ compensation, commercial, managed care, and Medicaid have different requirements for authorizations and billing, and each vary greatly based on different rules for prior authorizations, concurrent authorizations, and re-billing of corrections. Becoming acquainted with these nuances will help case managers be prepared. It’s also useful to be aware that Medicare-guided private and public payers have very different methodologies.

All payers, with the exception of Medicare, generally use pre- and concurrent UR, which can direct case managers when seeking approval for billing of medical necessity status.

Medicare, on the other hand, uses a set of decision-making criteria to determine appropriate level of care, which should be understood and followed by the hospital staff. It is the hospital’s responsibility to apply status criteria correctly on admission.

Additionally, in managed care, contracts are generally renewed annually, but Medicare billing and reimbursement rules can change far more frequently, so it’s important to stay abreast of regulatory changes.

An excellent way of ensuring an understanding of these methodologies and regulatory changes is through mock audits. During a mock audit, case managers appeal a denial, using information gleaned from these contracts to back up medical necessity.

Case management and avoiding denials

Case managers have a unique set of skills that includes clinical, coding, and UR expertise, and they can often assist in avoidance of denials within the revenue cycle by:

> continued on p. 8
Denials < continued from p. 7

- Assisting patient access staff members by correctly scheduling patient procedures as inpatient or outpatient based on payer criteria. Case managers’ understanding of medical diagnoses and procedures may help avoid an inappropriate status that was prescheduled by physician or hospital personnel.

- Understanding denial criteria. Case managers should have a general understanding of coding and apply their knowledge of patient condition documentation by assisting the health information management staff when a denial occurs due to a misapplied procedure, DRG, or ICD-9 code.

Authorization denials require not only administrative explanation, but also how medical criteria were met if the administrative denial is overturned. Benefit and preexisting condition issues are best resolved with clinical input, which a case manager can appeal or resolve with patient history, coding, and clinical documentation.

Case managers can help ensure accuracy of billing by reviewing the bill for correct patient status and correct level of care. Correct service period dates of admission and discharge, bed types charged, procedures, and observation hours entered are essential pieces of information case managers can review for accuracy. An understanding of coding methodology can also ensure that coding is accurate and complete for reimbursement. Knowing different payer methodologies such as per diem rates versus DRG rates and outpatient prospective payment system/ambulatory payment classifications reimbursement can also assist in determining inaccuracies in payer denials and assist with appeals.

Essentials for overturning denials

Denials can be difficult to capture and separate into categories by denial advice alone. They must be reviewed and researched to determine what went wrong and why. This type of expertise takes clinical knowledge as well as knowledge of all aspects of revenue cycle management.

A case management–coordinated denials management program can reduce and return millions of dollars of lost revenue. Understanding that each hospital stay is different is key to managing denials. Doing so will help effectively formulate trending that provides useful information to the healthcare team and to the revenue cycle.

Many denials are successfully overturned because of an individual’s knowledge and understanding of why the denial occurred—whether a medical or financial denial. Comprehensive understanding of the nuances of payer methodologies can result in a successful appeal, and a successful appeal will result in revenue that may have potentially been lost without this expert knowledge.

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Guarding against readmissions

by Anna J. Kiger, DSc, MSN, MBA, RN, NEA-BC, senior director of patient care services at Tenet Healthcare Corporation

According to the Institute for Healthcare Improvement, nearly 18% of Medicare patients admitted to a hospital are readmitted within 30 days of discharge, accounting for $15 billion in spending. Payers, including CMS and quality measurement groups, are considering methods to tie hospital payment to lower readmission rates. CMS intends to evaluate readmission rates as a pay-for-performance metric in the near future, which makes it imperative that your utilization review (UR) committee develop a cohesive plan to review the frequency and type of readmissions to your facility.

Unplanned readmissions after a previous hospital stay is a category of data used by payers to judge the quality of hospital care. Common types of unplanned readmissions would be a patient who is re-admitted to the hospital for a postoperative surgical wound infection or a patient who is readmitted for the removal of a retained foreign object. However, patients transferred to another acute care facility or a postacute care provider (e.g., a long-term care facility, SNF, or nursing home) typically do not count as a readmission.

The UR committee at each hospital should define what a readmission is and how it is calculated. Typically, the readmission rate is calculated by dividing the total number of patients readmitted within 7 days, 15 days, 30 days, and six months by the total number of hospital discharges for the time period selected.

In reviewing readmission rates, the UR committee should look at common diagnoses that appear to have a trend for readmission, such as congestive heart failure, asthma, or any postoperative procedure.

If you do not currently have a review process in place for evaluating the frequency and type of readmissions your organization experiences, now is the time to start a formal monthly review. Below are a few pointers:

➤ Note that there are several postdischarge events that can lead to unplanned hospital readmissions. These issues lead to a failed recovery for the patient and often an unplanned readmission to the hospital for additional medical care.

➤ It is important to determine whether the readmission is related to the index admission and how long after the discharge the readmission occurs. The reason for the readmission is often determined by reviewing the admitting physician’s notes. If the cause for the readmission is linked to the previous admission, the case should be summarized and reported to the UR committee for review.

➤ Some unplanned readmissions are not preventable. Although they should be counted as a readmission, the cause for readmission should be clearly identified in the review of the physician’s admission note.

➤ Regardless of the reason for the unplanned readmission, insurance companies and other payers sometimes view unplanned hospital readmissions as an overuse of already stretched healthcare dollars. CMS considers seven-day readmission rates at the 75th percentile or lower as being optimal. There are no published CMS benchmarks for 15-day, 30-day, or six-month readmission rates.

Case management plays a pivotal role in ensuring that patients experience an effective and safe discharge to the next level of care. Discharge plans that are planned and executed well will help reduce the rate of unplanned readmissions by giving patients the information they need after a hospital stay.
Preventing readmissions with appropriate discharge planning

Betty is admitted to the ED at The DuPont Hospital in Fort Wayne, IN. Betty is malnourished because she did not follow a proper nutrition plan after having extensive surgery for colon cancer. Betty is so malnourished she does not have the strength for physical therapy. She does not even have the strength to feed herself or to turn over. Because of this, she develops pressure ulcers and is moved to the ICU.

Case management intervention

Case managers are concerned because Betty is a single mother of four and does not have the necessary resources to get better outside of the hospital. With her poor condition, normal rehab will be too strenuous. In addition, she has deep vein thrombosis, which means she will require acute care and supervision after discharge. The care team explores every possible option with the patient.

Obstacles to discharge

Physicians suggest hospice as an option to Betty, but she is concerned because her children would not be able to visit her there as much as she would like. Case managers suggest a nearby SNF. However, Betty also responds poorly to this idea. She feels that a hospice or a SNF would be a step backward in her progress. Additionally, she does not like the idea of being around dying and elderly patients. She begins exhibiting signs of depression, and case managers are concerned that her low morale will deteriorate her condition. With this in mind, the case management team explores more options.

Discharge plan

Case management holds extensive meetings with Betty and her family regarding the options available. Together, they decide that a subacute specialty hospital in a neighboring town is the best option to address Betty’s physical and emotional needs.

A transfer to this facility means an immediate discharge. It is also hoped that this transfer will stabilize Betty’s emotional well-being. The resources at the facility are a perfect fit for her needs, including an on-site dietitian, nutritional monitoring, physical therapy, mental counseling, and interaction with other patients in her age range. Betty finds the social support she needs in this facility, which is a big boost to her emotional well-being.

Less than one week after Betty is admitted to the facility, she is able to ambulate with the aid of a wheeled walker. After two weeks, she is able to take five steps with a wheeled walker and is soon discharged home.

Lessons learned

In this scenario, case managers learned the importance of ensuring that patients have the proper resources to care for themselves upon being discharged from the hospital following major surgery or any life-altering event. Had Betty received the support she required after her initial discharge, she may not have fallen so ill and required readmission to the hospital.

Additionally, case managers learned the equal importance of a patient’s emotional and physical well-being. In this situation, case managers took both into account in hopes that it would help Betty make a full recovery and avoid yet another readmission to the hospital.

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