CalvertHealth®

Provider Orientation to Case Management

Noelle Flaherty, Director of Case Management, June, 2023

Integrated Case Management (ICM) Program

- Promotes the delivery of the right care to patients at the right time, place, and cost
- Interdisciplinary and covers all aspects of patient care services
- Designed to advance the efficient, cost effective, evidence-based quality patient outcomes

The performance improvement project for the ICM department is to **prevent avoidable readmission** and maintain an **all-cause readmission rate below 9%**

ICM Services in the Hospital

- Case Management Discharge Planning
- Social Work Consultation
- Social Determinants of Health Screening
- Emergency Room Case Management
- Palliative Care
- Medication Assistance Program
- Transportation Assistance Program

ICM Nurse Case Manager Model

- Every bedded patient is assigned a Nurse Case Manager who:
  - Reviews medical necessity criteria for level of care
  - Notifies the provider if the criteria is not met
  - Completes an initial assessment, including:
    - Current services
    - Potential barriers to discharge
    - Palliative care screening
    - Social determinants of health screening
  - Participates in interdisciplinary rounds
  - Refers for post-discharge services (e.g., skilled nursing, home health, or durable medical equipment)
  - Updates the discharge instructions and coordinates discharge once medically cleared

ICM Medical Social Work Model

- Social Work Consults may be ordered by providers or per protocol by nurses
- Common reasons for Medical Social Worker consults:
  - Suicide Risk Assessment and safety planning
  - Mental health treatment or crisis housing
  - Social determinants of health(e.g., substance use, housing insecurity, or interpersonal violence)
  - Follow up on reports of suspected abuse or neglect of a child or vulnerable adult
    - Note: As a mandatory reporter, the provider or nurse who initially suspects the abuse or neglect makes the report and then places a Social Work consult for follow up

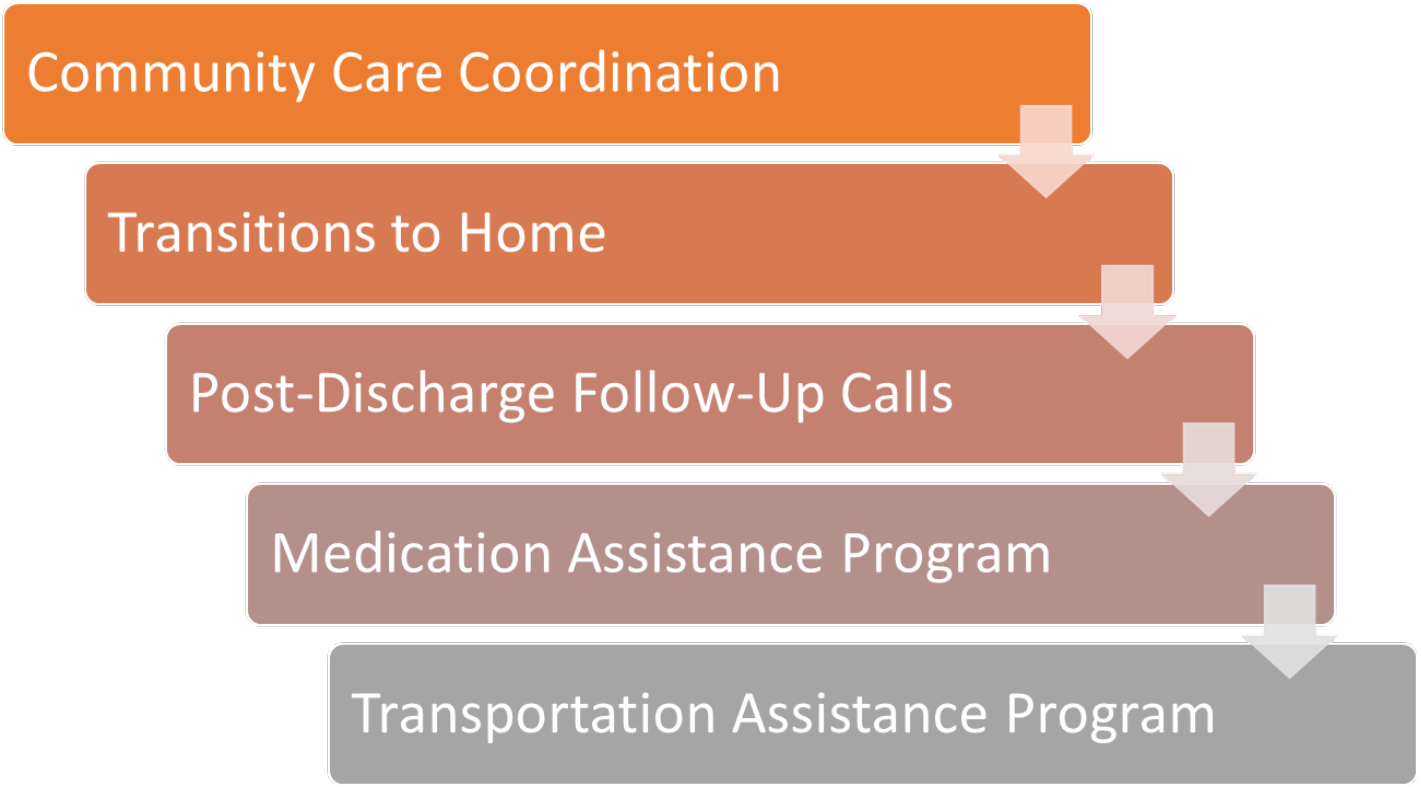
Provider Role

- Request medical necessity criteria from the nurse case manager when:
  - It is *unclear* if the patient should be in observation status, inpatient, or discharged
  - Converting from observation to inpatient
- Document the detailed medical reason for admission, continued stay, and conversion from obs to in
- Communicate regarding the anticipated discharge needs
- Consult the Medical Social Worker for any patient who is **high** or **medium** risk of suicide to ensure safety planning
- Complete an insurance company peer to peer call upon request when the stay is being denied and there is a clear medical need for the patient to remain hospitalized
- **Discharge orders and summary before noon when feasible.**

Other ICM Services

- The *Emergency Department Case Manager* facilitates services, appointments, and equipment for ED discharges
- The *Palliative Care Nurse Practitioner* and *Social Worker* provide palliative care services based on consult orders
- Non-clinical staff handle interpretive service requests
- Non-emergency discharge transportation is arranged based on patient needs
- Discharge medication assistance funding is provided based on financial needs and availability of funds
- After discharge, patients identified as at risk for readmission are followed by a nurse or a social worker in the Transitions to Home program

Case Management Interventions after Discharge



Contact Information

The daily census lists the CM assignment and provides extensions

- **Main office number**: 410-535-8235
- **Fax number**: 410-535-8224
- **Director:** 410-535-8217
- **Palliative Care Coordinator**: 410-535-8183
- **After Hours or Unable to Reach a CM**: Call the operator
- **Suspected Abuse or Neglect**: Call the Operator and for the Suspected Abuse or Neglect hotline or use the speed dial on your phone

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