

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 17**

POLICY TITLE: CASE MANAGEMENT AND DISCHARGE PLANNING

PURPOSE: Case Management is a collaborative effort between Health Care Services nursing staff, attending practitioners, patient and family and other health care providers to:

- promote continuity of care
- identify appropriate alternatives to hospitalization yet achieving cost-effective quality of care
- maintain patient and practitioner satisfaction of care that is coordinated
- avoid hospitalizations/exacerbation of disease through a pro-active approach maintaining or improving a patient's health status

PROCEDURE:

I. Patients Identified for Case Management

1. Patients identified for Case Management include those with such diagnoses as, but are not limited to the following:

- organ transplantation
- high-risk pregnancy
- premature births and low birth weights
- congenital anomalies
- major brain and/or spinal cord injuries
- major traumas including severe burns, amputations, and multiple fractures
- total joint replacements
- severe stroke
- severe altered pulmonary status
- HIV/AIDS
- progressive neurological disorders, including Multiple Sclerosis and Amyotrophic Lateral Sclerosis
- complications of Diabetes
- major cardiac disorders
- cancer
- major psychiatric disorders
- chronic substance abuse

Patients can be considered for case management services through member self referral, practitioner referral, discharge planner referral, Disease Management program referral and through identification by UM processes such as prior authorization of pharmacy, DME, referral process, pre-certification etc.

II. Inpatient Case Management/Discharge Planning

1. Discharge planning of hospitalized patients begins upon receipt of information of the impending admission or upon the initial review of the patient's hospital record.
2. Such cases as identified in Section I, #1 are discussed by the Case Manager and the attending practitioner/practitioner's staff, appropriate hospital staff (i.e.: Social Services and nursing personnel), and the patient and patient's family if appropriate.

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3. Case management is to focus on the full spectrum of needs of the patient and the patient's family support system. The acquisition of needed medical supplies and equipment, as well as home health services (skilled nursing care, physical therapy, speech therapy, and occupational therapy), is directed through contracted providers (whenever possible) and benefits are verified.
4. At times, service benefits may be extended if doing so results in a more cost effective management of the case i.e. reduction of hospital days. These benefit extensions are to be approved by the Chief Medical Officer and communicated to the Manager of Claims. This information is to be relayed to the Claims staff via documentation in the computer system.

III. Outpatient Case Management

1. Upon initiation of home health services ordered by the Health Plans' practitioner, the Case Manager will maintain communication with the home health nurse. The Case Manager will coordinate care with the home health agency as needed until the patient is discharged from care and resumes care from the attending practitioner.
2. As members are identified as high utilizers of Emergency Room services, (those patients accessing Emergency Room physicians in lieu of establishing themselves with a primary practitioner) will be discussed with the Chief Medical Officer. Upon the direction of the Chief Medical Officer, the Case Managers will assist these patients in establishing with a primary practitioner.
3. Patients who are identified as switching to multiple practitioners during a treatment course will also be discussed with the Chief Medical Officer. Upon the direction of the Chief Medical Officer, Case Managers will assist these patients in establishing with a primary practitioner.
4. On a weekly basis, data is retrieved from claims experience identifying patients with such diagnoses as listed in Section I, #1. The purpose of this data is to identify patients early in their disease state to provide intervention, which could potentially maintain their health status, to avoid hospitalization, or prevent a worsening of their condition.
This report is found at: Go to My Documents—H:Reports/Health Care Services Dept/Case Management All Groups (this is an excel report). Amounts are entered on the inpatient authorization's hospital screen under line # 9 as they are obtained from the facility business office. This needs to be updated on a weekly basis for large claim cases.
5. Patients identified as experiencing frequent hospital admissions, high utilizers of emergency department, high dollar pharmacy services, and high utilizations of outpatient services will be discussed with Chief Medical Officer. Under the direction of the Chief Medical Officer, the Case Managers will assist the member in establishing with a PCP or SCP, and other case management activities as indicated.

IV. Inter-/Intra-departmental Communication

1. At Health Care Services staff meetings, case management cases are held to discuss as described above.
2. Specific large cases are discussed with the Chief Medical Officer on an as needed basis.
3. Ongoing communications will be established with the member's PCP and referrals to SCP will be coordinated as needed.
4. The Finance Department is notified of all identified active/potential large claims via the Large Claims Report. This report is updated by the Case Managers on a monthly basis.

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V. Quality Improvement Monitoring

1. Member and Practitioner satisfaction surveys are conducted annually by the Quality Improvement Department to monitor level of satisfaction with non-institutionalized settings of care and also to identify ways to continuously improve case management services. Results are reported to Health Care Services Staff and Quality Improvement Committee.
2. Post Admission Outcome surveys are conducted by the Quality Improvement Department on all discharged patients (with exception of fetal demise) to determine the level of satisfaction with case management efforts. This is done on a monthly basis and the results are reported to Health Care Services Staff, Utilization Review Committee and Quality Improvement Committee on a quarterly basis.
3. To ensure inter-reviewer reliability complex cases are discussed as indicated at staff meetings to establish that the same criteria are used consistently by all Case Managers.

VI. Closure of Cases

1. Cases are considered closed when:
 - a. discharge planning is complete and patient is discharged home to follow up with the attending practitioner as needed.
 - b. discharge from home health agency to follow up with the attending practitioner as needed.
 - c. patient resumes care from the attending practitioner as needed.
 - d. patient expires.
 - e. benefits expire; case manager will notify appropriate parties.
2. The Case Manager will document in the information system the disposition of the patient.

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Date

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Original:	08/89	Revised:	05/96	Revised:	05/00	Revised:	11/06
Revised:	02/90	Revised:	06/96	Revised:	05/01	Revised:	03/07
Revised:	02/91	Revised:	05/97	Reviewed:	03/02	Revised:	03/08
Revised:	03/92	Reviewed:	03/98	Revised:	03/03	Revised:	03/09
Revised:	07/94	Reviewed:	02/99	Revised:	03/04	Reviewed:	02/10
Revised:	08/95	Revised:	04/99	Revised:	03/05	Reviewed:	02/11
Revised:	10/95	Reviewed:	02/00	Revised:	03/06	Reviewed:	01/12