We will get to staffing—but let’s start by reviewing core functions.

**Care Management**

As we have discussed previously, Care Management in the hospital setting is generally composed of Care Coordination, Discharge Planning, Utilization Review and Denial Management.

**Care Coordination and Discharge Planning**

Care Coordination is the process of ensuring that a patient receives care that is individualized, coordinated between disciplines and effective in meeting the patient’s care needs both in the hospital and post-discharge. Care Coordination is responsible for working collaboratively with providers and clinical staff to develop strategies for reducing or preventing readmissions.

Care Coordination, simply said, is coordination of care. Without an effective Care Coordination program, patients may stay too long – or be discharged too soon – or not receive evidence based care. The Center for Case Management has used the following statement to describe care coordination for many years,

“Plan for the Day” “Plan for the Stay” “Plan for the Way”

Organizing, facilitating and documenting multi-disciplinary meetings and/or multi-disciplinary rounds are also key functions of Care Management.

**Utilization Review and Denial Management**

Utilization Review in many rural hospitals is combined with Care Management and Discharge Planning.

Utilization Review is the process of determining if provider documentation supports medical necessity, if the patient has been placed in the correct status and obtaining any required third party payor authorizations. Utilization Review staff are usually also responsible for delivering the Important Message from Medicare regarding Discharge Rights as well as any Advance Beneficiary Notices. The goal of utilization review is to achieve appropriate reimbursement and prevent denials from Medicare and other third party payors.
Care Management cont.

Denial Management

Denial management is a critical element of utilization review. Although denials may be received by the business office, staff responsible for utilization review should always be involved in denial management for the purposes of: 1) Assisting with appeals; 2) identifying denial trends and 3) developing strategies to prevent future denials.

Care Management staff in many facilities are also responsible for the oversight and coordination of the Swing Bed program. For Swing Bed programs not in a Critical Access Hospital, a Minimum Data Set (MDS) coordinator or an individual assigned to complete the MDS may also be required.

**Care Management Staffing:** HTMS recommends 0.9 worked FTE for each ADC of 10 with a minimum 0.45 worked FTE.

Clinical Documentation Improvement

Clinical Documentation Improvement is concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation. These reviews usually occur on the patient care unit or can be conducted remotely (via the EHR). The goal of the review is to ensure that the clinical documentation supports the diagnoses, and procedures that are ordered and the ICD-9 (or 10) codes.

**Clinical Documentation Improvement Specialist:** HTMS recommends 0.9 worked FTE per ADC of 15.
Case Management

Outpatient Case Management is a process in which a person (alone or in conjunction with a team) manages multiple aspects of a patient’s care in the outpatient setting including provider offices and the patient’s home.

Case managers perform multiple functions including but not limited to: assessment, clinical monitoring, education, coordination of services, and advocacy to meet an individual’s and family’s comprehensive health needs. Emphasis may vary based on specific functions according to patients’ conditions and the primary objectives of specific case management interventions.

Outpatient Case Management may be provided to individuals of any age with complex care needs.

Case load may vary based on individual case complexity and the resources required. The Case Management Society of America (CMSA) has developed a caseload calculator that can be used to estimate case load based on a variety of factors. An e-survey conducted by HIN (Healthcare Performance Benchmarks) captured information from 153 healthcare organizations. The average monthly caseload for a case manager as reported by survey respondents is as follows:

<table>
<thead>
<tr>
<th>Case load</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 49</td>
<td>31.1 percent</td>
</tr>
<tr>
<td>50 to 99</td>
<td>42.2 percent</td>
</tr>
<tr>
<td>100 to 149</td>
<td>15.6 percent</td>
</tr>
<tr>
<td>150 to 199</td>
<td>2.2 percent</td>
</tr>
<tr>
<td>200 to 249</td>
<td>3.3 percent</td>
</tr>
<tr>
<td>250+</td>
<td>2.2 percent</td>
</tr>
<tr>
<td>Other</td>
<td>3.3 percent</td>
</tr>
</tbody>
</table>

**Case Management Staffing:** HTMS recommends 0.9 FTE per case load of 50 patients. Case load may vary based on individual case severity and complexity.

Social Work

Rural facilities do not always have a licensed social worker on staff and if not, those duties are frequently assumed by the individual responsible for Care Management. It’s important to note that although the Critical Access Hospitals (CAHs) Conditions of Participation (CoPs) do not require a licensed social worker – they do however, require the social work function.

C-0386 §483.15(g) Social Services: The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

**Interpretative Guidelines:** The intent of this regulation is to assure that all facilities provide for the medically-related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. A qualified social worker need not personally provide all of these services. It is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline.
Staffing Models

In Critical Access or small rural facilities, an integrated model with one or two individuals performing the majority of functions is common. In larger or more complex organizations, each function may be the responsibility of a different individual or team.

So let’s look at some potential models.

**Model 1**

- Combined functions of: Care Coordination/Discharge Planning, Utilization Review/Denial Management, Swing Bed Coordinator
- Clinical Documentation Improvement Specialist
- Community Case Management

**Model 2**

- Combined functions of: Care Coordination/Utilization Review, Denial Management, Swing Bed Coordinator
- Social Work / Discharge Planning
- Clinical Documentation Improvement Specialist
- Community Case Management

**Model 3**

- Care Coordination
- Utilization Review / Denial Management
- Social Work / Discharge Planning / Swing Bed Coordinator
- Clinical Documentation Improvement Specialist
- Community Case Management

**Your Model**

The permutations are endless of course. The type of model you develop will depend on the unique needs of your organization.

A tool with questions to help you determine your needs assessment tool is included on the next page.
It is extremely important that each organization review their unique characteristics including internal and external challenges to determine the types of staff and the FTEs required to be successful.

Toni Cesta, in her book, “Core Skills for Hospital Case Manager”, recommends that the following factors be assessed in determining appropriate staffing levels:

- Roles and functions of Care Management staff
- Roles and functions of other members of the interdisciplinary team
- Frequency of interdisciplinary care rounds
- Access point patient management (i.e. Emergency Department)
- Clerical support
- Software and/or processes to eliminate paperwork
- Payer Mix
- Intensity of service
- Complexity of patients
- Length of Stay

Recommended additions to the list include:

- Readmission Rate
- Denial Rate
- Case Mix Index
- Swing Bed Utilization
- Observation Utilization
- Availability of Community Resources
- Hospitalist Program
- Performance compared to external benchmarks (core measures, etc.)
- Population management

Assessments
# Roles and Functions

## Role and responsibility of Care Management

- How many roles are included within the scope of the care manager?
- If other roles are added, what are they and approximately how much time do they require on a weekly basis? These may include:
  - Follow-Up / Discharge Phone Calls
  - Clinical Documentation Improvement
  - Swing Bed Coordinator

## Roles other members of interdisciplinary team

- Is there an active / involved team including pharmacy, social work, staff nurses, physicians, ancillary depts.?
- Have roles and responsibilities for each discipline been carefully defined?
- Is the nursing staff responsible for basic discharge planning?

## Interdisciplinary Rounds

- Are there daily rounds? Is there active participation? What types of patients are your focus? All patients OR a discrete cohort who re or may be recidivists?
- Who is responsible for organizing rounds?
- Who is responsible for documenting the rounds including discussing the recommendations of the team with the patient and physician?

## Hospitalist

- Is there a hospitalist?
  - Generally a hospitalist promotes better coordination and easier follow-up than community physicians who are not in the hospital as frequently.

## Access point patient management

- Is there additional support at the point of entry, emergency department or admitting, to review medical necessity and communicate with providers?

## Clerical support

- Is there support for activities such as faxing, copying, ordering DME or arranging transportation?
  - If not, how much time do these activities require on a weekly basis?

## Software and/or processes to eliminate paperwork

- Is Case Management software being used?

## Payor Mix

- What is the payor mix?
  - Higher percent of managed care may mean more time spent on clinical reviews – Higher percent of Medicare may mean more time spent on complex discharges – Higher percent of Medicaid may require more attention to psychosocial issues and discharge planning.
### Roles and Functions

<table>
<thead>
<tr>
<th>Questions</th>
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</thead>
<tbody>
<tr>
<td>What types of services do you provide?</td>
</tr>
<tr>
<td>How many transfers do you have on a weekly basis? Is Who is responsible for facilitating transfers?</td>
</tr>
<tr>
<td>What type of patients do you serve?</td>
</tr>
<tr>
<td>Do they have complex clinical, psychosocial or financial issues?</td>
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<tr>
<td>What is your LOS? How does it impact the work of the Care Manager?</td>
</tr>
<tr>
<td>Both low and high length of stay may influence work load.</td>
</tr>
<tr>
<td>Is your readmission rate higher or lower than the national average?</td>
</tr>
<tr>
<td>Did you receive a reduction in payment from Medicare due to your readmission rate?</td>
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<tr>
<td>Do you have significant issues with discharging patients to community providers or to home due to lack of resources?</td>
</tr>
<tr>
<td>What is your denial rate?</td>
</tr>
<tr>
<td>What is your Case Mix Index?</td>
</tr>
<tr>
<td>Could it be improved with a dedicated Clinical Documentation Improvement Specialist?</td>
</tr>
<tr>
<td>What is your Swing Bed Utilization?</td>
</tr>
<tr>
<td>How much time does it take to coordinate the Swing Bed Program?</td>
</tr>
<tr>
<td>Who is responsible for coordinating the Swing Bed Program?</td>
</tr>
<tr>
<td>What is your observation rate?</td>
</tr>
<tr>
<td>Who is responsible for managing observation to ensure a continuous cycle of assessment and reassessment?</td>
</tr>
<tr>
<td>How are you performing compared to external benchmarks (core measures, etc.)?</td>
</tr>
<tr>
<td>Are you at financial risk for managing a population or cohort of patients.</td>
</tr>
<tr>
<td>Are you involved in a shared risk arrangement?</td>
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</tbody>
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If you have questions or comments about this newsletter, please contact Carolyn St.Charles, Regional Chief Clinical Officer. Email: carolyn.stcharles@ht-llc.com. Office: 360-584-9868 Cell: 206-605-3748