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| Subject: Care Management | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
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POLICY:

Every patient on the [Program name] will be assigned to Care Management (RN/SW) responsible for:

1. Utilization review to ensure that criteria for admission and continued stay are met.
2. Acting as the liaison between the patient/family, medical provider, and the interdisciplinary team.
3. Providing or overseeing medical social services needs.
4. Overseeing and facilitating discharge planning activities.

PROCEDURE:

Utilization Review:

# Care Management will assist the physicians to determine which inpatient admitted to [name of hospital] meet admission criteria for skilled level of care.

# Care Management will review clinical data for external referrals and discuss with the team as needed to determine whether they meet skilled care criteria and whether the patient’s needs can be met at [program name].

# He/she will determine eligibility as to whether the patient has skilled care days based on Medicare criteria.

# Pre-authorization will be obtained for non-Medicare payors as applicable.

# Registration will be notified of patients being admitted from acute at this hospital or from an external hospital to [program name].

# Consent for medical care and financial responsibilities will be signed by the patient or representative.

# Continuity of skilled care needs will be determined through the interdisciplinary team process based on patient’s skilled needs identification, progress or lack thereof based on discharge goals.

Discharge Planning:

# Care management will visit with the patient/family on the day of admission (except on weekends and holidays) [change if you have coverage 7 days/week] and assist in the orientation of the patient using the Orientation Packet.

# A nurse from the swing bed unit will be assigned the review of the orientation packet specific to skilled level of care when the patient is admitted on weekends or holidays and the care manager will re-discuss with the patient/family upon their return to duty to ensure that all information is clear and allow the patient/family to ask new questions they may have. [remove # 2 if you have 7-day coverage].

# Care management will complete a comprehensive discharge planning assessment within twenty-four (24) hours post admission (except weekends and holidays) [remove content of parenthesis if 7-day coverage].

# Following the discharge planning assessment, he/she will review the care plan initiated by nursing and add to it as appropriate to ensure that the patient’s psychosocial needs, anticipated outcomes and subsequent interventions are implemented as soon as possible.

# Care management will plan and facilitate all Interdisciplinary Team Meetings, follow through on discharge planning, scheduling of patient/family team conference as needed, making necessary arrangements in community, and ordering equipment, etc. in preparation for discharge. All of this information with be documented as they occur.

# Document information related to patient/family as needed in progress note based on physician, IDT, any nursing staff etc.

# Document all patient and family encounters in the discharge progress notes on the day they occur.

# See P&P re: Interdisciplinary Team Process for more information.

Other Duties:

# Assistance with guardianship and conservatorship service when indicated.

# Assistance regarding claims for public assistance, medical assistance, social security benefits and any other similar agency or service.

# Assistance with adjustments to the program, and/or their disability, need for continuing assistance and communication with the patient, guardian, family, or other responsible persons.

# Provide patient/family education and supportive counseling (or will see to it) to assist them to deal with new physical limitation, new diagnosis, death & dying etc.

# Continued assistance to include community resources exploration and referral.

# Advocacy assistance to support patient’s rights.