# Merrimack Valley Hospice

## CASE MANAGEMENT EDUCATION

# I know what case management is!

# Don’t I?

# What is a Case Manager?

- The Case Manager (CM) is responsible for the total patient including the clinical and psycho-social interventions needed
- The CM plans and coordinates the plan of care with the team, other providers and with the patient/family
- The CM updates and revises the plan of care when a new problem or new interventions are needed. This is done on an ongoing basis
- The CM is not dependent upon the manager to make day to day decisions about patient care; it is a collaboration
- The Case Manager manages the “whole” patient

# Case Manager Human Characteristics

The Case Manager must……..

- Be flexible
- Be assertive
- Make mature decisions
- Maintain a positive attitude
- Take responsibility for their actions
- Take the initiative to manage difficult situations

# Case Manager Human Characteristics

- Take responsibility for positive patient outcomes
- Hold themselves and their IDT team accountable
- Be a team player
- Demonstrate confidence in making decisions about patient care
- Be a critical thinker

# Case Manager Responsibilities

- The Case Manager coordinates the complete care of the patient and family
- Understands the importance of human and customer relations
- Utilizes resources of the agency in a responsible manner
- The use of critical thinking to troubleshoot and "forecast"
- The relationship with IDT members is one of trust and respect
- The priority is on patient care and outcomes, everything else comes second
- Thoroughly understand the Medicare Hospice Benefit

# To Be Effective……

- It's about planning and communication!
- Planning for the implementation of the plan of care-
- By each visit
- For each week
- For the certification period
- At each IDT meeting

# How do I do this?

- Daily Planning
- Review your schedule
- Think- how will a visit today accomplish the implementation of the POC?
- What will I accomplish with a visit today to this patient?
- Prioritize patient needs:
- Patient new to Hospice
- Patient with symptom management needs
- Family/caregiver education needs

# Daily Planning

- Are there emotional /family dynamic needs to be addressed?
- If I visit today- what happens for the rest of the week?
- Does the hospice aide need support or direction?
- Is there imminence of death?
- What are the IDT members planning for their visits to this patient?
- Perform a quick run through of these questions as you plan your day
- Call the patient/family to set up the visit schedule early in the morning.  Do not call from the road.
- The goal is be where you have to be, on time, all the time!

# What to accomplish on each visit:

- Physical assessment- changes in mobility, function, skin, elimination, sleep patterns and current management of symptoms
- Mental status/Cognitive assessment-changes in mentation, speech and affect
- Check in with family- Coping status, reassurance needs, education, concerns, emotions and the ability to safely provide care
- Look at the medications-*visually* assess for adequate supply of meds, anticipate need for ordering on that day
- Review the supplies for adequate amount-anticipate ordering need

# What to accomplish on each visit:

- Confirm the next visit date with the family-you take charge of the visit schedule based on your  assessment.
- Do not ask the family when do they think they need the next visit-be confident in your schedule and planning
- Make phone calls from the patient home to order equipment, meds, supplies or to  speak to physician or communicate with other IDT members.
- This way the family is aware that you are following up on their needs/requests and may be able to implement changes that day

# What to accomplish on each visit:

- Document in the home-
- Information is accurate
- Offers opportunity for reinforcement of information with patient/family
- Provides current information for on call staff
- In long run-saves time

# Speaking of documentation……

- At each visit, determine the patient's current eligibility for the Hospice benefit based on today's assessment
- Use the FAST and PPS scales to quantify status/change in status
- Is there continued decline? Weight loss, disease progression?
- Symptom management of greater concern
- Psychosocial/emotional issues becoming more labile
- Also, document keeping in mind the patient's certification period, is this patient eligible for recert? Or consider patient's status in relation to the remaining days of the current cert period

# Collaboration

- Collaboration with the LPN
- How to best utilize the valuable resource of the LPN-consider the individual skills
- Again, look at your schedule-what visits are appropriate for the LPN
- The LPN supports the plan of care, schedule visits that require reinforcement of the plan of care: symptom management, patient/family education, ongoing assessment
- The LPN is not to be used for crisis management
- Consider continuity for LPN visits; if the patient receives two visits a week, one visit can be made by the LPN on an ongoing basis

# Collaboration

- Collaboration with the IDT members
- Have an awareness of IDT visit frequency and their plan of care
- Stagger visits so not to overwhelm family
- Do make joint visits to address a specific need
- You are each other's expert and support system
- Prepare IDT notes as a team member, not as a separate entity

# The IDT Meeting

- The IDT is the "heart" of hospice
- To develop an interdisciplinary "plan of care" (POC) that meets the evolving needs and *goals* expressed by the patient and/or family and reviews the progress towards these desired outcomes.
- To review, revise and document this POC as patient's condition requires but no less frequently than every 15 calendar days.
- To coordinate services and show how all services are working to meet goals.

# Focus of the IDT Meeting

- IDT will define patient and family goals.
- IDT will plan how each discipline and the team as a whole will support patient and family in meeting their goals and achieve good outcomes in the following two weeks.
- IDT will report how each discipline and the team as a whole has supported patient and family in meeting their goals in the past two weeks (outcomes).
- IDT will document these goals, interventions, and outcomes in an IDT note.

# What are goals?

- **A goal is a desired result or outcome** that a person or a family envisions, plans, and commits to achieve.

- Goals are
  - Wishes
  - Concerns
  - Hopes
  - Needs

# Sources of Goals

- Patient stated …
- Family member related patient likes to …
- Caregivers voiced patient used to enjoy…
- Patient would like to continue …
- Patient and family hopes to be able to …
- Family wishes to ...
- Patient wants to ….
- 5 Wishes/Living will declares …

# Sources of goals

- Patient has always wanted to…..
- Patient requested …
- When discussing … patient related…desire to…
- Caregivers voiced the hope …
- Caregivers hope to be more confident in…
- Caregiver would benefit from…
- Recent change in condition results in new goal of …

# Case Scenarios

- You are planning your day when you receive a phone call from a patient's wife stating that her husband's (your patient) foley catheter is clogged and he is in a lot of discomfort.
- She asks if you can come to do a visit as soon as possible to change the catheter. You were planning to see this patient today, but at the end of the day as it made more sense geographically
- How will you manage this situation?
- What must you consider?

# Case Scenario

- You and the SW have been seeing a family with dynamic issues. The patient is a 50 year old man with esophageal cancer and is unable to take in food orally and has pain that is difficult to manage
- This morning you receive a phone call from the wife who is crying and shrieking. It seems the patient's sister has arrived from out of state and is demanding information about why he can't eat and why is he in so much pain. The patient is fearful and upset
- How will you manage this situation in relation to your visit  planning?
- The patient is not scheduled for a visit today