**PURPOSE:** Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services, to meet an individual's health needs through communication and available resources, thus promoting quality, cost-effective outcomes. MCDOH RN Case Managers will oversee all aspects of home and patient care as they relate to the plan of care, arrange for additional services as needed, coordinate care with physician’s orders, and advocate for the patient’s best interest.

**DATE ADOPTED:** December 2010

**REVISED:** November 2011

**POLICY:** Applies to: Maternal Child Program RN Case Managers

The Case Management Process is to ensure improvement or at least optimize the quality of life for the patient and family in the home setting.

**Phase I:**

Review of information obtained from the discharging facility/OB history/Aubry Tool.

1. Thoroughly review history and physical.

2. Review discharge medication list for any allergies, high risk medications, drug interactions, new medications.

3. Look for chronic illness and/or co-morbidities that may affect the patient’s recovery.

4. Determine what skilled services the patient needs from the preliminary information as well as what is reasonable and necessary.

5. Look for any noncompliance issues noted.

6. Establish if family and/or caregivers are available to help as needed with the patient’s care and are capable of providing care.

**Phase II:**

Assessment in the home.

1. A head-to-toe assessment is performed, determining what skilled services are needed and any problems identified.
2. Identify:
   a) Caregiver support
   b) Physician involvement
   c) Financial and socioeconomic indicators, including payor source
   d) Day of assessment medical status and psychological indicators
   e) Medication assessment
   f) Functional assessment, including environmental factors
   g) Psychosocial assessment
   h) Cultural and religious diversity
   i) Identify the patient’s/family’s perception of health care goals

Phase III:

Development and coordination of the case of plan, not the care plan.

1. The needs and services for the patient are matched into a seamless plan based on the assessment data and the desires of the patient/family/caregiver.

2. The case plan must promote the patient’s optimal level of self-care and control over his or her life.

3. Collaboration for services is made at this time with ancillary services, physician, pharmacist, payor, family/caregiver and the patient.

4. The multidisciplinary team and the patient/family need to decide:
   a) What needs to be done
   b) How to best do it
   c) Who will provide necessary services
   d) When each need will be met
   e) Where and when the next level of care will be provided
   f) How the patient/family can best manage after discharge

Phase IV:

Implementation of the case plan. Coordination and facilitation is the goal of this phase to maximize the safety and well-being of the patient, using the most independent and necessary care.

Phase V:

Evaluation and follow up. Are the case plan goals and objectives met, partially met or not met at all?

1. Have appropriate treatments, procedures, or case management interventions been selected?
2. Are all the essential needs of the patient and family been identified and addressed?

3. Are the services being delivered as planned?

4. Have new needs or issues surfaced that would cause an adjustment in the case plan?

Phase VI:

Closure of the case.

1. Start discharge planning at the start of care to enhance a smooth departure.

2. Educate the patient/family in advance that the patient will be discharged.

3. Answer questions from the patient and family.

4. Alleviate the patient’s and family’s anxiety.

5. Refer and/or set up for community resources if applicable.