Review **CMS regulations** pertinent to case management, such as:

- Criteria for observation status (symptom) and inpatient status (diagnosis)
- Transfer to SNF: Choice of SNF by patient if able, or family
- Public health follow up for patient with tuberculosis
- O₂ saturation requirement for home O₂
- Medicare Important Message: what do if disagree w/discharge; in effect for 48 hours
- Inpatient stay of 3 overnights to qualify for SNF
- Eligibility for Medicare, criteria
- Medicare, part D: prescription drugs
- 100% coverage by Medicare for first 20 days in SNF
- Medicare coverage for SNF: must relate to diagnosis in hospital stay
- Custodial care, may be covered by Medicaid, but not Medicare

Review **documentation** requirements, such as:

- Use of AHCA MedServ-3008
- Discharge form to SNF includes where patient will go after SNF
- Need to document communication with family
- Code 44 – patient admitted as inpatient, does not meet criteria
- EMTALA, signature verifies acceptance of transfer
- Documentation for home health, reason for need

Review the **scope and role of the Nurse Case Manager**, including:

- Responsible to determine patient’s understanding and acceptance of plan
- Prior to discharge home, assess travel to medical appointments
- Risk for readmission: co-morbidities
- Transfer to SNF: First step, identify facilities approved by insurer

Review **principles of safety**, such as

- Handwashing rather than only hand sanitizer when patient has C. diff
- Risk of falling, elderly patient taking benzodiazepines

Review **principles of communication**, including:

- Patient satisfaction, importance of continuous communication
- Advocate for patient’s preference for hospice
- Assess caregiver knowledge when patient admitted for observation w/hypoglycemia
- Recommend that family explore SNFs at Medicare website, nursing home compare
- Communicate with family about name and location of SNF to which patient is discharged