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Case Management Directors

How to Manage in a Transition-Focused World: Part 2

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ABSTRACT

Purpose and Objectives: Case management directors are in a dynamic position to affect the transition of care of patients across the continuum, work with all levels of providers, and support the financial well-being of a hospital. Most importantly, they can drive good patient outcomes. Although the position is critical on many different levels, there is little to help guide a new director in attending to all the "moving parts" of such a complex role.

This is Part 2 of a two-part article written for case management directors, particularly new ones.

Part 1 covered the first 4 of 7 tracks: (1) Staffing and Human Resources, (2) Compliance and Accreditation, (3) Discharge Planning and (4) Utilization Review and Revenue Cycle. Part 2 addresses (5) Internal Departmental Relationships (Organizational), (6) External Relationships (Community Agency), and (7) Quality and Program Outcomes.

This article attempts to answer the following questions:

- Are case management directors prepared for an expanded role that affects departments and organizations outside of their own?
- How does a case management director manage the transition of care of patients while managing required relationships outside the department?
- How does the director manage program outcomes in such a complex department?

Primary Practice Setting: The information is most meaningful to those case management directors who work in either stand-alone hospitals or integrated health systems and have frontline case managers (CMs) reporting to them.

Findings/Conclusions: Part 1 found that case management directors would benefit from further research and documentation of "best practices" related to their role, particularly in the areas of leadership and management. The same conclusion applies to Part 2, which addresses the director's responsibilities outside her immediate department. Leadership and management skills apply as well to building strong, productive relationships across a broad spectrum of external organizations that include payer, provider, and regulatory agencies. At the same time, they must also develop the skills to positively influence the revenue cycle and financial health of both the organization for which they work and those to whom they transition patients.

Implications for Case Management: A director of case management with responsibility for transitions of care has more power and influence over patient safety than is commonly known. Few of the directors who are drawn from clinical case management or other leadership positions and thrust into this role are prepared to navigate within the organization, much less across the whole spectrum of payer, provider, and monitoring organizations. Yet the external focus of the director's role continues to grow in importance as the health care industry evolves and more focus is placed on population management and relationships with payers and community providers.

Key words: *case management, case management administrator, director, liaison, postacute providers, relationships, revenue cycle, transition of care, value-based purchasing*

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One of the things that make a director of case management so unique is the breadth of influence she has, both inside and outside the hospital. The acute care hospital was once the center of health care delivery, but today patients move routinely out of an acute care hospital to another level of care, such as a skilled nursing facility. The process of transferring or referring a patient from one level of care setting to another or from one specialized service to another within the same setting is called transition of care. Recent changes in health care legislation, economics, and delivery models have expanded transitions of care across multiple levels of care, adding complexity to the transition process.

If transition of care can be thought of as the bridge spanning the space between the hospital and the next level of care, then the director is the one responsible for erecting and maintaining that bridge—actually, multiple bridges—and for building relationships on both ends. To carry the analogy one step further, the director also has a financial obligation to the hospital to provide the highest quality spans at the most competitive price.

We believe that directors in this role, particularly those new to the position, could use some help. Often, directors of case management positions are filled by individuals who excel clinically, but have had little or no leadership training or experience. They learn as they go, which can be a high-wire act for someone who serves as the face of the hospital with patients and external providers and makes decisions every day that impact the hospital's bottom line.

In recent years, there has been movement toward changing the selection and evaluation process for those moving to a position of leadership from a largely clinical position. We believe that these advances in hiring must be extended to training, development, and support after hiring so that the new director has the tools to manage not only her organization and transitions of care but the multitude of external partnerships and relationships that must be maintained as part of the process.

Even with these advancements, there has been very little about the case management director's role in available literature and a lack of practical guidance from any other resources. This article is intended to fill that gap and to provide case management directors, particularly new ones, with a template for organizing basic functions and identifying areas that may require their evaluation and attention.

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Scope of Part 2

To better organize our research and communicate what we learned, we have outlined seven tracks of responsibility for a director of case management (see Table 1). Part 1 of the article covered the internally focused topics of staffing, compliance, discharge planning, and utilization review—all things that a director of case management needs to know to do her job. Part 2 addresses responsibilities related to organizations—both internal and external to the hospital—that are outside the director's immediate supervisory scope, and the financial impact a director's actions could have on the hospital's revenue cycle. Part 2 is about how to apply the knowledge gained in Part 1.

Please note: Throughout this article, the term *director* will be used to signify a case management department director in a short-term acute care hospital.

Seven Tracks of Responsibility for Case Management Directors (Tracks 5–7)

Track 5: Internal Departments

Case management directors interact in some way with almost every department inside the hospital. In the normal course of your day, you will communicate and collaborate with a number of different people whom you do not supervise, but must find a way to influence if you want to do your job effectively. You may also serve on committees such as the Ethics, Compliance or Quality Assurance Committee, where you will participate in decisions and help set direction that could have far-reaching impact on the hospital. The best way to do all of that well is to understand the roles and the goals of the people you work with and to make sure they understand what you do, and why it is important that you work together (American Medical Association, 1994).

Direct Report

Meetings with your direct reports should happen on a regular schedule with interim meetings as required.

TABLE 1
Seven Tracks of Responsibility for Case Management Directors

Part 1

1. Staffing and human resources
2. Compliance and accreditation
3. Discharge planning responsibilities
4. Utilization review responsibilities

Part 2

5. Internal (organizational) departmental relationships
6. External (pre- and postacute organizational) relationships
7. Quality and program outcomes

One way to ensure that everyone is moving in the right direction is to collect relevant information and use it to highlight trends in transition management that affect the overall success of the hospital. For example, with the current emphasis on readmissions, the director might use the available data to identify trends with a particular physician or agency that may warrant further review.

Although data are powerful, stories can sometimes carry at least as much weight. Sharing success stories of how difficult placements were made or discussing how barriers to discharge were overcome brings the focus back to the patient. Make sure that your administration understands the dilemmas you and your staff face on a daily basis in managing transitions. Always come to the table with ideas for improvement or ideas for solutions.

Department of Nursing

Possibly the most important department with which the case management department interacts is the Department of Nursing. Staff nurses do a number of things that impact transitions of care, such as:

- provide 24/7 care to patients,
- interact with families at all hours,
- educate the patient/family on what needs to be done after discharge, and
- interact frequently with the patients' physician and other clinicians.

In addition, staff nurses perform the required admission assessment, which is a critical source of information used in discharge planning. Medical issues, psychosocial issues, and the care the patient was receiving prior to admission should all be documented in the medical record, and findings communicated to the case management staff.

Staff nurses are expected to participate in discharge planning, which means that they can identify patients at risk for an adverse health outcome after discharge, a delay in discharge, or other potential issues that could make the discharge less safe and efficient. Staff nurses are vital contributors to rounds and should be part of that process on a consistent basis.

Social Services

Social workers can report to the case management director, but they can also work in a separate department that must be closely aligned with the transition of care process. Social workers contribute skills and experience that are particularly relevant to patients being discharged to the community. For example, patients in a medical unit that provides services to stroke patients can benefit from the input of a social worker because of the impact of stroke on the patient's functional status, not only basic activities of daily living, but also on instrumental activities of daily living. The best working relationship with a social worker is one built on trust and an appreciation for the unique skills, perspective, and network the social services bring to the patient population being served.

Ethics Committee

Decisions that discharge planners and physicians make in transitioning patients affect the patient after discharge and outside the hospital. Patients are also part of the decision process, but they can sometimes make decisions about their own care that carry potential risk. Making sure that patients have a choice about available and appropriate options and that they are made aware of any potential areas of risk can sometimes require input from the hospital's Ethics Committee. In turn, the Ethics Committee can often benefit from the input and guidance of the case management director so that members have a clear and accurate understanding of how the transition process should work.

As the director of case management, you are often the best conduit to make sure that the right facts and information are moving in both directions

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between your department and the Ethics Committee. You should consider a permanent seat on the Ethics Committee or, at the very least, make sure that you have access to the committee when time-sensitive situations arise.

Physician Relationships

The relationship with physicians is one of the most important for a case management director. As a matter of course, you will interact with physicians across a variety of positions, departments, and specialties. To be successful in these relationships, you must work to develop professional alliances with all physicians and to understand their roles and responsibilities in the transition of patients. Only physicians can write admission and discharge orders and finalize a discharge plan. At the same time, physicians depend on the skill and expertise of the case management director's staff to get their patients home or to the next level of care. Understanding how a physician or physician group is related to the hospital is important. Whether the physician is a hospitalist in a contracted group practice, a member of an accountable care organization (ACO), or a direct employee of the hospital has influence on the interactions when writing orders for postacute care services.

Another group closely related to physician relationships includes those individuals who are in the status of nonphysician practitioner (NPP). These individuals include nurse practitioners, clinical nurse specialists who work in collaboration with the physicians, certified nurse-midwives, and physician assistants who work under the supervision of the physician (in accordance with individual state laws). As with the other roles discussed here, your power in the relationship comes from understanding the various NPP roles and making sure that NPPs understand your goals and their role in a successful care transition.

Physician Advisors

Directors and the physician advisor are essential partners in maintaining relationships with all physician groups. As we move from a volume-based physician practice model to a value-based patient-centered model, the physician advisor has a unique set of skills to lead, educate, and interact with both internal and external entities. Although there are not formal standards, one group working to promote physician advisor networking, education, and industry standards is the National Association of Physician Advisors. Strong networking with other successful physician advisor programs is recommended and this is a great place to start.

Physician advisor models vary by hospital or system. Whether you outsource the role or employ your own advisor, each hospital adapts different aspects of the role as it best fits the goals of the organization. Most cover aspects of physician education, compliance, documentation accuracy, utilization review, appeals, length of stay, and health care information technology (IT). Making daily rounds with the case managers not only keeps them aware of issues but allows for visibility and communication with all members of the care team. The physician advisor should be well versed in the data surrounding length of stay (LOS), avoidable days, and documentation issues. Having a peer present performance data to the medical staff is much more palatable than having it come from a nonphysician.

Whatever strategy you employ, it should promote autonomy of the medical staff physician practice while leveraging their expertise to promote quality care through the adoption of evidence-based care. The physician advisor is critical to bringing your physicians to the table to develop and apply these best practices. Education is an important part of the role, so do not forget to include other areas like interventional radiology and departments that are not unit based yet impact patient care.

Information Technology Team

Health informatics has taken on greater importance throughout health care and particularly in case management. The type of work required in Utilization Review and Discharge Planning requires a great deal of documentation specific to those functions. Often, this information is not captured by other departments and can be quite complex.

Many case management departments have several different software programs intended to streamline the workflow while capturing critical data. It is important as a director that you are aware of all the programs and sources of data available to your department and that you are familiar with how they work so that you can make sure that they are being used to their fullest capability.

It is also important to be familiar with the IT decision makers at your facility so that you can have appropriate input into the IT roadmap for future changes. Network with those decision makers and make sure you listen to their goals. Be prepared to educate them on your department's needs relative to transition management. Have your "elevator speech" prepared. Let them know that you can be a resource for them in evaluating technology. With any technology change for transition management, include the members of your staff who will be most impacted in the evaluation process. Make sure that both the vendor and your IT department have a clear understanding of the problem you need to be solved by the technology.

Once the plan is in place, it will be your responsibility to implement the technology. Having enough resources is always a challenge, but never more so than when you have the extra challenge of going live with a new product or multiple products. Anticipation of go-live dates can be made a little less painful with the help of extra, but experienced, staff. Build in some overtime hours or extra staffing when possible. Planning ahead to block or limit vacation requests during go-live is usually a good move as well. The best technology available can be made far less effective if not implemented with the appropriate resources, training, and support.

Quality Assessment and Program Improvement

Case management and care coordination are defined parts of health care operations activities (SOM, 2014). Being part of hospital operations carries a burden of producing outcomes and participating actively in specific initiatives, such as the hospital-wide Quality Assurance Performance Improvement (QAPI) program. Directors of case management are in a unique position to identify opportunities for improvement of outcomes of discharge planning interventions. As a director of case management, you, in collaboration with hospital administration and the QAPI team, will always be expected to revise your discharge planning and related processes if they are identified in any way as contributing to preventable readmissions. Consistent with the requirements under the QAPI CoP, the hospital's governing body, medical leadership, and administrative leadership are also responsible for ongoing reassessment to achieve improvement (SOM, 2014).

Taking the time and effort to participate in the wider QAPI program will not only allow for support of a significant department but also let all departments know the importance of case management and the transition management work being done.

Legal Department

The mission of a hospital's legal department as applied to case management departments is to provide guidance when issues arise that could impact the legal rights of the patient, family, and organization. Because so much of transition management has the potential to affect the legal rights of all parties, a director must always bring hospital legal counsel in when there is any question about the legal rights of any party.

For example, a patient with no one to speak for his or her rights and whose ability to make decisions about his or her own care is impaired might need a conservator. You and your staff should always be on the lookout, even in the early stages of hospitalization, for any possibility that legal advice will be required so that you can bring in the legal team and they can begin their work as soon as possible.

In addition, all policies written for the case management department, particularly those involving transition management, must include the advice and counsel of the hospital legal department.

Track 6: External Organizations

The case management director is often the face of the hospital to all of the external organizations that touch on transitions of care. How you interact with this diverse community of providers, payers, regulators, and monitoring organizations directly influences the way the hospital is perceived.

Many of these organizations are covered by the same laws and regulations as you, including privacy rules, duties to report, and the requirement to send timely and appropriate clinical information to the next provider of care. Determining where your hospital's responsibility ends and the counter party's responsibility begins is one of the challenges in transition management. If a postacute care provider accepts a transfer of a patient and the provider requests additional information after the patient has been discharged, how is the request handled? Having a policy about how to give the provider the information is critical.

Some external organizations you work with might also be governed by a different or additional set of rules. To be an effective advocate for your patients and to make sure your organization stays in compliance, you must be aware of them all so that you know when and how to ask the right questions and where to look for answers.

The list of external organizations with which a director must have collaborative relationships is long, but here are some of the most common.

Payer Organizations

In the world of health care delivery, competition among hospitals has grown dramatically. Those that can provide high-quality services at a competitive price have the advantage because that is what payer organizations are looking for. Hospitals negotiate contracts with payers to provide a set of services at a specified price. The contract usually includes wording related to how the hospital provides for Utilization Review, including admission review and continued stay, and discharge planning. Hospitals, especially larger ones or those that are part of a hospital system, will have contracts with multiple payer organizations. If you want your hospital to get paid for the elements of the contract you provide, you and your staff must understand the terms of each one and know how to meet those terms.

If you are a new director, review copies of the contracts in place with each payer organization. Contracts are not always easy to find, but they are critical if you want to understand your responsibilities with payers. Because you will be charged with carrying out many elements of the contract, participate in contract negotiations when possible. Make sure that the chief financial officer knows you can add value in reviewing proposed contracts before signing.

Postacute Care Organizations

More than any other, the case management department is the hospital's link to the postacute provider community that cares for your hospital's patients after discharge. As the leader of the case management team, you are responsible for these relationships and must dedicate the time and energy it takes to make and keep them strong. Strong working relationships with the provider community provides for smooth transitions and avoids the issues that cause delays and result in unnecessary patient backup.

Managing the transition process requires that the case management staff understand the level of care, admission criteria, services provided, and usual payment source for multiple providers of postacute care. There are a multitude of ways to promote an understanding of these elements at other levels of care. One is to have new staff visit several kinds of postacute facilities, including an inpatient rehabilitation center, a skilled nursing facility, and a home care agency. Talking with postacute counterparts at each level of care and gaining an understanding of what they need from the hospital throughout the transition process are a great way to identify potential barriers to communication.

Another good practice is for the director to schedule regular meetings with postacute providers to review throughput initiatives, LOS by level of care, and, if available, metrics or data points on provider performance. On the basis of what your data show, you might spend time with a particular facility trying to understand its high rate of avoidable readmissions. Other impact topics you might discuss with your providers are response to referral times, reasons why a patient referral is declined, and what other information might be needed to accept a specific patient's referral.

Define what metrics you can share with individual postacute providers while being sure not to share protected information. For example, you might be able to share referral rates for one skilled nursing facility (SNF) with that SNF, but not the referral rates for other or all SNFs.

Become familiar with the CMS Compare at the Centers for Medicare & Medicaid Services (CMS) website. There you can find quality and other data for many postacute type organizations in a database that is updated regularly (CMS, 2014a, 2014b, 2014c). With these data, individual organizations can be compared with similar organizations within the same geographic region, which is useful when trying to select the right postacute facility for a patient from among many similar candidates. To access the data, type CMS Compare and the type of provider you are looking for into your web browser. This service does not provide availability of services for individual facilities. Use a commercially available transition management program to check availability.

It is also important to note that each level of care is required to do discharge planning similar to what a hospital does. A valuable resource provided by the CMS for hospitals on what the patient can expect at the next level of care can be found in a Medicare Learning Network (MLN) titled "Discharge Planning" (MLN/CMS, 2013).

Care Coordination Organizations

Case management directors are often required to work with care coordination organizations, which are not direct providers of care, but organizations that work with patients and families during an episode of care. An episode could last from days to a lifetime, or as long as a patent meets the criteria of that specific organization. Both public and commercial payers frequently work with organizations that specialize in managing care delivered to a patient. For example, ABC care coordinators could contract with DCE Insurance Company to manage all the home care needs of their enrolled members. If a patient who is a DCE Insurance Company subscriber needs home care, the hospital would verify the enrollment and then contact ABC to coordinate that patient's home care needs. This is a growing trend because home care has become so complex, and arranging, implementing, and monitoring the delivery of care is more intricate.

Many states have what is referred to as a "waiver" program, meaning that the requirements for admission to a service are reviewed on a case-by-case basis. The goal of many of these programs is to have the patient receive services in the community rather than in a nursing facility. An example is Programs of All-Inclusive Care for the Elderly (PACE), which coordinates community-based services for elders (CMS PACE, 2011).

Shared Savings Programs

A "shared savings" program is one in which an external organization manages the care of a set number of Medicare/Medicaid beneficiaries for as long as the beneficiaries are enrolled in that program. The program is managed by a collaborative group, including physicians and other clinicians. Any savings realized

in comparison to members not in the savings program is shared with the program by Medicare. For example, if an ACO has 5,000 beneficiaries enrolled for coordination of care and that ACO spends $100,000 less per year than CMS paid for care for 5,000 non-ACO members, the ACO will receive a percentage of the $100,000 savings. The incentive in shared savings programs is to provide quality care more efficiently.

You and your staff must have a working understanding of all the types of shared savings programs that admit patients to your hospital. It is good practice to have all the information for the contact person at each type of organization.

Like care coordination programs, shared savings programs must produce quality care at less cost, and provide evidence that they have met minimum patient care outcomes. Your role in a shared savings program is to be aware—and make your staff aware—of this accountability and how it is impacted by the quality of care the patient receives after discharge.

Ambulance (Medical) Transportation Services

Transition of care of a patient always involves some sort of transport service. Although it might sound simple to get a patient from one location to another, setting up transport can be one of the most time-consuming elements of a patient's discharge plan. There is also an inherent risk involved in moving a patient because a patient's care needs do not stop during a transport.

The choice between patient transporting by private car, wheelchair van, or ambulance can be critical. If by ambulance, it is important to provide the transport/ambulance personnel with all the information they need to provide appropriate en route care during the ride or flight (CMS Ambulance, 2014). Make sure your staff knows what information to communicate to a transport service, such as the patient's condition, the presence of any infectious disease, special needs, or advanced directive wishes (if applicable). A warm hand-off is important for continuity of care.

The business relationship between a hospital and a transportation company requires a great deal of attention. Ambulance companies bring patients to and take patients away from hospitals and can influence the hospital patient numbers as a whole. Directors should work closely with administration to ensure that all guidelines and requirements are being met, and that the collaboration with transportation providers and suppliers is part of the everyday workings of the department. Metrics such as delays, turnaround times, and the inability to arrange transport should all be tracked. Metrics can drive performance and throughput initiatives when used in a collaborative discussion with the transport companies.

Knowing the distinction between a ambulance providers and ambulance suppliers is important (CMS MLN, 2011). An ambulance *provider* is a provider who owns and operates an ambulance service as an adjunct to its institutionally based operations. An ambulance *supplier* is not owned or operated by a provider and is enrolled in Medicare as an independent company.

Be creative. If you do not have a way to get to the transport data, rest assured that the transport company does. Sit down with their representatives and talk through trends at your facility in transport request volumes/times/days of week. Would the volume warrant a transport coordinator? Could you have calls with dispatch at set times each day to coordinate anticipated needs? Can you communicate electronically to arrange rides and share information? Sitting down together and making sure that you are consistently and effectively providing your transport partners with everything they need leads to better partnerships and better fulfillment of your transport needs.

Protective Services

Violence in all forms is one of the unfortunate realities that case managers deal with, and not only in emergency departments. Clinicians in most states are mandatory reporters of suspected or real abuse, neglect, or exploitation of at-risk groups of individuals. Children and the elderly are in the class of individuals with specific protections. Other situations such as rape or other intentional harm suffered by a patient may have specific reporting requirements.

Because these programs are managed by states, the case management director must ensure that the staff is aware of what constitutes abuse, neglect, or exploitation and how and when to report it. You and your staff should obviously know and understand the reporting requirements for your state, but think about your location. You must know the rules for neighboring states as well if your hospital is located close to a border.

During the process of assessment, a case manager may be made aware of an underlying situation and she must investigate the situation and report as required. Often, a patient—who may or may not be a victim—will share information in confidence with the case manager. Case managers must have a resource available to discuss the implications of shared private, but potentially harmful, information. The patient's physicians, the Ethics Committee, hospital legal services and you are all good options.

Clinical Liaisons

Case management directors who work with care coordination clinicians known as "liaisons" face

Compliance for discharge planning and utilization review for hospitalized patients are the responsibility of the hospital, regardless of who is providing the service. Basic services, such as discharge planning and utilization review, cannot be delegated by the hospital to non-hospital-employed individuals. However, clinical liaisons do have a role to play in discharge planning.

unique challenges. Liaison staff are clinicians who are on site at a hospital but work for an organization outside the hospital. Compliance for discharge planning and utilization review for hospitalized patients are the responsibility of the hospital, regardless of who is providing the service. Basic services, such as discharge planning and utilization review, cannot be delegated by the hospital to nonhospital employed individuals. However, clinical liaisons do have a role to play in discharge planning.

Liaisons work in various capacities and can be important in the flow of transition of patients. In your role as a director of case management, you are in a position to maximize the value of the services offered by liaisons, while ensuring that all other duties and responsibilities to patients and the organization are met.

Skilled and knowledgeable liaison clinicians offer benefits that are well known. They can provide a service that is important to the transition of patients, particularly when patients are complex, hard to place, or have specific clinical service needs. Because of the complexity of the roles and functions associated with liaisons, the relationship should be clearly defined by the organization with consistent rules and protocols regarding liaisons and how they are credentialed. Credentialing of a liaison is different from credentialing of medical staff. Information needed for an on-site liaison relationship may include the following:

- a letter from the liaison's employer outlining the liaison's planned functions and duties;
- a copy of the liaison's license;
- a plan to orient the liaison staff to the hospital's policies and procedures, particularly infection control, fire safety, and access to medical information; and
- contact information at the employing organization in the event of an emergency or a situation that the director needs to clarify.

If you plan to work with liaisons, you need to establish a method for gathering the information, determine the department that will hold the information, and develop a system for monitoring the status of each liaison.

Payer Liaisons

How a payer liaison is used is often spelled out in the type of plan and the type of contract your hospital has with the individual payer. A health maintenance organization (HMO) may indicate in the contract that the plan have an employee on site to work with hospital staff for its own members. As such, when an enrollee of that HMO needs postacute care, the arrangements may be made by the payer's on-site liaison. Commercial payers and workers' compensation providers could also have case managers who act as liaisons.

The contract between the HMO and the hospital should make clear to the patient the role of the individual working on his or her behalf. It should specify, for instance, who talks to the physician advisor when the question of medical necessity for a specific postacute care arises, and when hospital staff should escalate the interpretation of medical necessity to the payer medical director.

As a director of case management, it is your responsibility to talk with the payer in situations where the insurance liaison has proactively denied the type of postacute care requested, or suggested a type of postacute care not endorsed by the hospital clinicians.

Postacute Care Liaison

Many hospitals have what is referred to as postacute provider liaisons who are not employees of the hospital. If you have one or more, be sure that you have a protocol in place for working with that liaison that is reviewed by your administrative group and the compliance officer.

In 1995, the Office of Inspector General issued a Special Fraud Alert regarding referrals from hospitals (CMS OIG, 1995). This fraud alert discussed the issue of ensuring that the work of liaisons does not influence selection of the agency to which a patient is referred, and reiterates that it is the hospital's responsibility to provide discharge planning services.

Directors of case management working with postacute care liaisons must be clear that liaisons participate in the day-to-day operations of the case management department to facilitate the transition of care of a patient referred to the agency they represent. They should have no opportunity or ability to

influence the selection of the agency they represent, and they should never be used in place of a hospital's staff.

That does not mean that a liaison should not participate in the discharge process. Liaisons provide a valuable educational resource because they are knowledgeable about the level of service they represent and which patients may be appropriate for the facility they represent. A hospital case manager might invite a liaison to meet with a patient, but only after the patient has been informed of the liaison's relationship with the hospital and the postacute facility she represents. That means that postacute care liaisons should not attend rounds where patients not already referred to their organization are discussed.

In some cases, liaisons also work for DME companies that provide special equipment and may be on site to evaluate the patient, do patient education, and coordinate the delivery and setup of that specific equipment.

Liaisons Who Work for a Health System and Act as Intake Coordinators

Just to add to the challenge of managing liaisons, the same term is sometimes used to refer to a role that exists inside the hospital or the hospital's system. Clinicians who coordinate referrals made to a level of service that is owned by the hospital or is a distinct part or unit of the hospital are called either an intake coordinator or a liaison.

For example, a hospital may have an inpatient rehabilitation facility unit and, to ensure that the patient is appropriate for that level, the inpatient rehabilitation facility liaison is called to see the patient and review the medical documentation. If the liaison/intake coordinator is an employee of the organization, that individual is working under the rules, regulations, and standards of the organization and therefore may not need to be separately credentialed.

Part of your job is to clearly distinguish the roles and be sure that there is no confusion by other staff members, the liaison, or the patient.

Track 7: Quality and Program Outcomes

The impact a well-run case management department can have on a hospital's revenue cycle is enormous. The work done by case managers in collaboration with medical staff to ensure that the patient's care in the hospital is medically necessary and cannot be provided in another setting is the cornerstone of reimbursement. This may read like an oversimplification of a complicated process, but the bottom line is that what case managers do matters when it comes to submitting a claim for services rendered. How the payment rules are followed depends on how well they are known by those on the front line. As a director, you are accountable for knowing the payment rules and for ensuring that staff working in the department are aware of the rules, understand their responsibilities, and know how to coordinate levels of care options with physicians. The decision to admit to observation status or inpatient status is one example of an opportunity to collaborate with physicians and to provide the appropriate level of care for patients. Utilization review standards do not often change, but the interpretation of how they are applied for payment can change, with the hospital's revenue cycle and what the patient ends up paying as major considerations (CMS COP, 2014).

Value-Based Purchasing

The emerging changes in how CMS pays for services—based on quality instead of quantity—provide directors of case management with significant opportunities to positively influence the revenue cycle.

The Affordable Care Act includes a method of reimbursement called Value-Based Purchasing (VBP), which is being advanced across health care settings in the Medicare program as part of the 2010 Patient Protection and Affordable Care Act. Value-Based Purchasing is a method of reimbursement that links financial incentives to providers' performance on a set of defined measures. The purpose of introducing a performance-based model is to drive improvements in quality while slowing the growth in health care spending (CMS, 2013). Two of the core VBP elements where directors can have the most influence are as follows:

1. Medicare Spending Per Beneficiary, commonly called the efficiency score, and
2. Patient Experience of Care survey, or Hospital Consumer Assessment of Health Care Providers and Services (HCAHPS, 2015).

Individual Hospital Scores for VBP are publicly posted on the CMS website under Hospital Compare (CMS, 2014a, 2014b, 2014c). Consumers and payers are using this information when deciding which hospital to use for services. It is not just about revenue anymore. A hospital's quality ratings matter now.

Readmission

The overwhelming focus on readmission means that this is an important revenue cycle topic. Directors must be aware of the facts that go into readmission payment, such as the 30-day window. You must also be able to evaluate the impact of the discharge plan on the risk-adjusted readmission rate. If a patient is readmitted from a postacute level of care like a SNF or Home Health Agency, one of your tasks is to figure

out why. You should have the tools and ability to find the root cause of a patient's readmission and look at trends over time or across facilities, if appropriate.

One way to do this is to study readmission reports. If you have a patient who readmitted from a SNF, look at the readmission report and the overall ratings for that SNF. If it was an avoidable readmission, work with the SNF collaboratively to identify opportunities to improve care (Hunter, Nelson, & Birmingham, 2013). Factors that have been shown to predict the possibility of an unplanned readmission can be used by both the hospital and the postacute provider. Use of a tool referred to as the LACE (length of stay, acute admission through the emergency department [ED], comorbidities and emergency department visits in the past six months) index score is an example of a predictive model tool (Gilbert, Rutland, & Brockopp, 2013). The LACE index has been used to predict the risk of unplanned readmission within 30 days after hospital discharge.

Documentation

Whatever documentation system or method a hospital has in place—an Electronic Health Record, paper, or a combination of both, it must be considered when setting policies and standards for documentation of Utilization Review and Discharge Planning.

Utilization review documentation policy is established by the Utilization Review committee in collaboration with the Health Information Management (also known as Medical Records), the compliance officer, and administration.

Utilization Review

How much of the Utilization Review work done, if any, should be included in a patient's medical record is a decision made by each institution. Because a review of the medical record for legal or denial and appeal purposes is always a possibility, the director should ensure that the review findings are accessible to those who have authority and a need to know. The frequency, content, and sending of review information should be determined on the basis of the contract between the payer and the hospital.

Discharge Planning

Unlike Utilization Review documentation, it is required that Discharge Planning documentation be maintained in the patient's medical record. The information must be accessible to all clinicians who work with the patient and with the case manager on discharge decisions. Be sure that your policies on frequency of documentation, content, and style are clearly outlined and used consistently by case managers.

Clinical Documentation Improvement

If you have clinical documentation improvement (CDI) staff in your department, be sure that you understand their purpose and make sure that there are firm policies in place for the program. The CDI programs focus on improving the quality of clinical documentation, no matter how it impacts the revenue cycle. According to AHIMA, "…[a]rguably, the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures" (AHIMA, 2014a, 2014b).

For details on expected competencies of individuals in the CDI role and staffing models that have been used in other organizations, read the website "Guidance for Clinical Documentation Improvement Programs" (AHIMA).

Clinical documentation improvement is not only about the revenue cycle but also about the accurate reporting of what happened to a patient during an episode of care. This accurate documentation will follow the patient to the next level of care and be included in research and reportable statistics that will eventually be used to improve the quality of care.

Case Management Director's Role in Program Outcomes

One of the clearest measures of success for a director of case management is how she impacts the bottom line. It is certainly not the only way to measure your success, but it is one of the most concrete because targets and performance are measureable.

There are commercial software programs that measure case management productivity by collecting data across multiple organizations. The data elements vary by program and goals of the administration of a hospital. If your organization participates in programs that use health analytics, you will want to understand what data are being used to measure your performance, and you will want to participate in the setting of program goals.

Clinical documentation improvement is not only about the revenue cycle but also about the accurate reporting of what happened to a patient during an episode of care. This accurate documentation will follow the patient to the next level of care and be included in research and reportable statistics that will eventually be used to improve the quality of care.

Directors are in a unique position because their own performance goals, and those of the staff assigned to transition management functions, are dependent on the efficiency of organizations over which they have little control. When participating in goal setting, you must be thorough and articulate when identifying the specific elements on which your performance should be measured. For example, the LOS for patients who are referred to a SNF does not depend solely on the efficiency of the hospital case manager. It can also depend on the response times of multiple organizations, including the SNF, the payer (if preauthorization is needed), and the ambulance company (if transport is required). Elements of LOS over which a director of case management has direct control include early identification of a patient's need for SNF level of care, completion of required communication, collaboration with the pharmacist for medication reconciliation, contacting the family by a social worker, when needed, and arranging transportation.

That is not to say that you have no influence over the elements of the process for which you are not directly responsible. You can influence performance and outcomes for both internal and external partners by developing strong working relationships that allow for an open exchange of ideas and information and identification of opportunities for improvement on both sides.

You must also be clear if there are barriers to achieving your goals within your own department. It may be that the staffing ratios keep your team from accomplishing all the steps needed for your caseload. Keep in mind that performance is affected not only by numbers of patients per case manager, but by the scheduling of existing staff as well. Do referrals to a SNF made on a Friday take longer because there is no weekend coverage? Are there avoidable admissions due to a lack of case management coverage in the emergency department?

Think beyond LOS. Look at proactivity of discharge planning. What percentage of referrals are sent out within 24 hours of discharge? 48 hours? 72 hours? Look at performance by level of care. Can individual staff be more proactive? Also, incorporate provider performance metrics.

- *Staff*: Is the assessment for the discharge plan completed within the specified time frame?
- *Facility*: Tracking avoidable days can often identify internal and external factors that affect throughput and quality.
- *Provider*: Metrics surrounding performance of your postacute providers and addressing any issues those metrics identify can lead to better patient outcomes.
- *Payer*: Monitor denials and delays surrounding authorization for transitions to other levels of care.
- *High-volume MS-DRGs*: Look at LOS, cost, outliers, and quality indicators to determine what programs you can put in place to address chronic conditions and management of that population.

Benchmarking of Data Elements

The need to perform at a particular level is a common goal. Benchmarking is used to evaluate or check a specific performance measure by comparison with a standard. The benchmark for percentage of referrals made to home health care is a common indicator. Directors need benchmarks to set expectations, but the source of the benchmark must be reviewed to determine if it is a reasonable comparison number.

For example, Medicare reports that, on average, about 19% of patients are readmitted within 30 days (CMS, 2014a, 2014b, 2014c). In the Inpatient Quality Measures, there are elements that risk adjust readmissions. Even with the risk adjustment, the director's work is not done. The readmission rate for your hospital must be further analyzed. What is the readmission rate for patients who were discharged to, and admitted from, a SNF? What was the reason for the readmission? Is there a quality issue with a particular SNF and, if so, what can you do to work with that SNF to improve the quality (CMS, 2014a, 2014b, 2014c)?

Directors who are accountable for performance measures must be involved with the hospital-wide Quality Assurance program because case management is one of the central departments that affects the outcome of other departments and the hospital as a whole.

Conclusion for Tracks 5–7

The role of the director of case management is growing in both responsibility and opportunity when it comes to managing the transition of care. Transitions of care are increasingly being identified as one of the most important and risk-filled events of a patient's hospital stay. As a result, the need to separate that function from others is evident. The responsibilities that span the organization and across the continuum are relationship based, and the case management director's role as a leader is paramount. As concluded in Part 1, with the cost of health care, with the increasing focus on quality of care, and with the shortened length of stay for those who qualify for admission, the need to provide services to all patients in the system has made the job of a director of case

management one with seemingly limitless responsibilities. The additional conclusion for Part 2 is that the relationships fostered and maintained by the director also affect the financial well-being of the hospital and the other providers of care. The article was written with the intent to raise awareness of specific topics that a director needs to focus on, and for hospital administrators to understand the complexity of that role.

Use Parts 1 and 2 to review the scope of your work and as a discussion tool to establish best practices for your organization, your staff, and your colleagues in the community.

This article is not meant to be considered legal advice but is a set of topics and thoughts set up as a tool for directors to share knowledge and experiences, and that can be evaluated for use in your own organization.

Implications for Case Management Practice for Tracks 5–7

A director of case management with responsibility for transitions of care has more power and influence over patient safety than is commonly known. Few of the directors who are drawn from clinical case management or other leadership positions and thrust into this role are prepared to navigate within the organization, much less across the whole spectrum of payer, provider, and monitoring organizations. Yet the external focus of the director's role continues to grow in importance as the health care industry evolves and more focus is placed on population management and relationships with payers and community providers.

Parts 1 and 2 of this article demonstrate the breadth of knowledge and information that is needed to provide transition management services to patients; standardize practice across a single department or a large system; use compliance actions as a way to assess internal processes; and influence the financial well-being of both the hospital and the postacute partners who provide ongoing service to patients.

References

AHIMA. (2014a). *Guidance for clinical documentation improvement programs*. Retrieved June 18, 2014, from AHIMA Body of Knowledge: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047343.hcsp?dDocName=bok1_047343

AHIMA. (2014b). *Guidance for clinical documentation improvement programs*. Retrieved August 4, 2014, from AHIMA: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047343.hcsp?dDocName=bok1_047343

American Medical Association. (1994, June). *Opinion 9.11—ethics committees in health care institutions*. Retrieved June 17, 2014, from the American Medical Association website: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion911.page

Centers for Medicare & Medicaid Services. (2014a). *Hospital compare*. Retrieved June 18, 2014, from the Medicare Hospital Compare Quality of Care website: http://www.medicare.gov/hospitalcompare/search.html

Centers for Medicare & Medicaid Services. (2013, August 2). *CMS final rule to improve quality of care during hospital inpatient stays*. Retrieved January 25, 2015, from http://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2013-fact-sheets-items/2013-08-02-3.html

Centers for Medicare & Medicaid Services. (2014b). *Hospital quality initiative*. Retrieved October 10, 2014, from Outcome Measures: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/OutcomeMeasures.html

Centers for Medicare & Medicaid Services. (2014c). *Hospital quality initiatives*. Retrieved October 10, 2014, from Inpatient Measures: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/InpatientMeasures.html

CMS Ambulance. (2014, January). *Ambulance fee schedule*. Retrieved June 22, 2014, from Payment System Fact Sheet Series: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbulanceFeeSched_508.pdf

CMS COP. (2014, September 26). *State Operations Manual–Appendix A*. Retrieved January 25, 2015 from, https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

CMS MLN. (2011, May). *Medicare ambulance services*. Retrieved January 25, 2015, from Department of Health and Human Services: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Ambulance_Services_ICN903194.pdf

CMS OIG. (1995, August). *Federal register: publication of OIG special fraud alerts*. Retrieved June 21, 2014, from Department of Health and Human Services: https://oig.hhs.gov/fraud/docs/alertsandbulletins/081095.html

CMS PACE. (2011, January). *Quick facts about programs of all-inclusive care for the elderly (PACE)*. Retrieved June 22, 2014, from Centers for Medicare & Medicaid Services: http://www.medicare.gov/Pubs/pdf/11341.pdf

Gilbert, P., Rutland, M. D., & Brockopp, D. (2013, November 21). *Redesigning the work of case management: testing a predictive model for readmission*. Retrieved January 25, 2015, from http://www.ajmc.com/publications/issue/2013/2013-11-vol19-SP/Redesigning-the-Work-of-Case-Management-Testing-a-Predictive-Model-for-Readmission

HCAHPS. (2015). *HCAHPS online*. Retrieved June 18, 2014, from HCAHPS Hospital Survey: http://www.hcahpsonline.org/home.aspx

Hunter, N. B., Nelson, J. R., & Birmingham, J. (2013). Preventing readmissions with comprehensive discharge planning. *Professional Case Management*, *18*(2) 56–65.

MLN/CMS. (2013, October). *Discharge planning*. Retrieved August 4, 2014, from Medicare Learning Network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf

SOM, C. (2014). *CMS SOM-A*. Retrieved May 24, 2014, from CMS State Operations Manual - Appendix A: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

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