

## OPEN

# Case Management Directors

## *How to Manage in a Transition-Focused World: Part 1*

Cheri Bankston-White, RN, MSN, and Jackie Birmingham, RN, BSN, MS, CMAC

### ABSTRACT

**Purpose and Objectives:** Case management directors are in a dynamic position to affect the transition of care for 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. The purpose of this two-part article is to provide case management directors, particularly new ones, with a framework for understanding and fulfilling their role.

We have divided the guide into seven tracks of responsibility. Part 1 discusses the first four 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.

**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 reporting to them.

**Findings/Conclusions:** 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. New directors would benefit from mentoring and networking with one another.

**Implications for Case Management:** As new regulations and models of care bring increased emphasis and focus to transitions of care, the role of the case management director continues to evolve, growing in importance and complexity. The growing financial impact of readmissions also brings added scrutiny and increased pressure to get the transitions of care right the first time.

To operate most effectively, case management directors must understand the full range of their responsibilities and impact. They must find opportunities for themselves and their departments to learn and stay current as the regulatory environment continues to change. Providing a list of functions for which they are responsible, practical strategies for carrying them out, and places to go for help and information can help hospital case management directors operate with the confidence and knowledge they need to influence the quality and safety of patient care for the entire care team and to provide the best possible interactions with patients and family members.

**Key words:** case management, case management administrator, director, discharge planning, transition of care, utilization review

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. This position has become increasingly critical and visible as hospital survival has become more dependent on patient outcomes and management of the revenue cycle. Case management is in the spotlight now more than ever, but why are we sharing what we have learned with others? With demand high for directors of case management, positions are sometimes filled by individuals who excel clinically, but have had little or no leadership training or experience. In recent years, there has been movement toward changing the selection and evaluation process for those moving into a position of leadership

from a largely clinical position, as described in this excerpt from a study by the Institute of Healthcare Improvement to Transform Care At the Bedside (Hall, 2006; Lee, Peck, Rutherford, & Shannon, 2008).

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Address correspondence to Cheri Bankston-White, RN, MSN, Director of Clinical Advisory Services, Curaspan Health Group, Clinical Advisory Services, 212 Summer Hill Rd, Madison, MS 39110 (cbankston@curaspan.com).

The authors report no conflicts of interest.

DOI: 10.1097/NCM.0000000000000078

Years ago staff nurses were promoted to management positions based on clinical skills and technical competencies. As a result, front-line managers were not adequately skilled to address the array of interpersonal issues and complex, ever-changing priorities. The selection process for today's front-line nursing managers is far more robust than in years past, often requiring advanced degrees and leadership experience. Changes to the hiring and development models are imperative to address the rapid changes in the clinical, technical, and social changes in the health care workplace.

We believe that these advances in hiring must be extended to training, development, and support after hiring so that new directors have the tools not only to manage their organization, but to manage the transition of care, which may come to consume the majority of the work, time, and resources in a case management department.

## FIRST, SOME DEFINITIONS

The function of a case management director, sometimes called an administrator, is described in the *Handbook for Certification of Case Management Administrators* as follows:

“Case Management Administrators lead organizations in the development and implementation of strategies to achieve clinical, financial, and quality outcomes. Their activities may include direct supervision, education, consultation, and evaluation” (CFCM, 2014)

No one would blame a case management director reporting to work on the first day for being overwhelmed. A director's many duties fall into broad and varied areas of responsibility that include financial accountability, leadership, evaluation, monitoring and communication, and care transitions. Successfully navigating any one of these categories is challenging. To do them all well requires someone who can think critically, prioritize appropriately, and manage time effectively.

## FOCUS ON TRANSITIONS OF CARE

The acute care hospital was once the center of health care delivery. Not anymore. Patients routinely move 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. Case management directors are responsible for the transition of care process, which can be as complicated as it is important. 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 and the case management director's role. There is a significant risk to the hospital if the transitions of care are not done safely, efficiently, and in compliance with the many rules and regulations that govern them. On the other hand, it is at these transition points where the case management director is in a unique position to influence the quality of the care a patient receives and the cost of providing that care.

## ALL THE REST

In addition to transitions of care, case management directors must address the basic operational issues of staffing and budgeting. They must operate the department in compliance with the multiple sets of rules and regulations—beyond transitions of care—that directly impact the hospital as a whole. They will have to develop and maintain effective and productive relationships with both internal and external parties, demonstrate program outcomes, and, last but not least, be cognizant of the financial impact their actions could have on the revenue cycle of the hospital.

It is a good thing case managers (CMs) by nature are tenacious and focused on getting the job done because, until now, they have been learning the ropes on their own. There has been very little written about the case management director's role in available literature and a lack of practical guidance from 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.

We approached the task by grouping the case management director's many responsibilities into seven basic tracks. Part 1 includes the first four tracks, which we consider to be knowledge-based

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*Some hospitals organize assignments according to service line. In service line-based units, teams are trained to care for a particular patient type. They also interact routinely with the physicians who care for those patients.... Unit-based assignments offer many efficiencies because work generally takes place in one location. That allows for ongoing relationships with staff on the unit and the physicians who usually provide care to the unit's specific group of patients.... Another assignment model links CM staff to individual physician practices. The benefits of this model include the development of working relationships with physicians or physician groups.*

building blocks of transition management, or what the case management director *needs to know*. Those blocks are staffing and human resources, compliance and accreditation, discharge planning (DP) and utilization review (UR) and revenue cycle.

Part 2 talks about *how to apply the knowledge* gained in Part 1. We discuss the last three tracks, which include internal or organizational departmental relationships, external or community agency relationships, and quality and program outcomes. Successful execution of these duties requires judgment, interpersonal skills, and the ability to make decisions and translate action into revenue cycle and program outcome impacts, specifically around transition management.

Please note that although this article organizes the responsibilities of the case management director into specific areas of responsibilities, we do not mean to imply that this template applies to all directors in all situations. One of the characteristics of a successful director is the ability to be flexible in applying principles of management in a variety of situations, and in particular when situations are complex.

Also note that throughout this article, the term “director” is used to signify a case management department director in a short-term acute care hospital.

## SEVEN TRACKS OF RESPONSIBILITY FOR CASE MANAGEMENT DIRECTORS

### Track 1: Staffing/Human Resources

Hiring the right people is possibly the most important function a director carries out. A successful case management department begins with the staff. To find the right people, start with the organization's mission and the types of patients it serves. Using those two fundamental tenets as a starting point, identify the skills, qualities, and experiences staff members need to provide the best case management services for the organization.

The content of this section deals with the unique characteristics and functions of a CM department and finding the right people who embody those

characteristics and can carry out those unique functions. In addition, Table 1 presents a list of factors that can be used to drive critical hiring decisions.

### Staffing Models

There is more than one way to staff a case management department, and each model has its benefits and drawbacks. Some use a combination of the models below. These are some of the most common methods:

#### By Service Line

Some hospitals organize assignments according to service line. In service line-based units, teams are trained to care for a particular patient type. They also interact routinely with the physicians who care for those patients. One thing to watch for in a service line model is the location of patients. A patient who belongs to a particular service line can be placed anywhere in the hospital, but still have an “expert” CM watching the case to make sure it progresses as expected. Several CMs on the same unit trying to cover different patients all over the hospital could have difficulty accessing computers to get medical records. Physical space could be a challenge and the CM could end up working with different care teams for each patient, making communication about the case with doctors and nurses difficult. With the

**TABLE 1**

### Seven Tracks of Responsibility of 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-/postacute organizational) relationships
7. Revenue cycle accountability

comorbid conditions associated with acute care today, service lines become “blurred,” and the logistical challenges of the service model could decrease productivity of the CM staff.

### **By Unit**

Unit-based assignments offer many efficiencies because work generally takes place in one location. That allows for ongoing relationships with staff on the unit and the physicians who usually provide care to the unit’s specific group of patients. This model works best when the CM assigned to a unit is willing and able to call in other CMs for patients who are “off-service” or have special needs. Using each other as experts is important in a unit-based program.

### **By Physician or Physician Group**

Another assignment model links CM staff to individual physician practices. The benefits of this model include the development of working relationships with physicians or physician groups. For example, hospitalist groups provide medical oversight to a service line of patients, medicine, intensive care, surgery. If a CM is assigned to a physician, the evidence-based medical practice adopted by the physician group can be more efficiently carried out. One note of caution—with this model, the director must ensure that the case management staff focus on the inpatient population and do not take on extra work that is usually managed by the physicians’ ancillary staff. A physician may call on a CM for a patient he is seeing in his office for assistance in setting up services. This may prevent an admission, but the time it takes to facilitate a plan of care for a noninpatient must be considered. The number of times a CM is requested to facilitate continuity of care for a patient, either after discharge or not ever having been admitted, who being seen in the physician’s office should be closely monitored.

### **Staffing Ratios**

A search of available literature and current studies produced by national case management organizations produces no consistent formula or approach on staffing a case management department. Determining the number of staff needed for a case management department can be complicated and a number of variables must be considered, but it starts with the two basic functions that must be staffed: UR and DP. Because discharge planning is the most patient-centric function, staffing patterns should be organized to ensure that staff have enough time to spend with patients and families face to face.

As a minimum, a case management department must have nurses and social workers dedicated to the function of transition management. Other variables

to be considered include the volume and complexity of referrals. Staffing ratios should be based on available data such as the number of referrals made for postacute care on a unit-by-unit basis and the complexity of those cases. Not all cases are created equal. Medical patients, such as those on neurology, may require more complex referrals than a patient in an obstetrical unit. The number of patients assigned to staff members should be adjusted accordingly.

Staffing should also address the wide variety of functions assigned to the case management department, the types of patients being seen, and the available resources in the postacute setting. Urban settings frequently have more resources—but also more patients—whereas rural settings have fewer accessible resources and significant transportation issues.

The ability to have transparency into the workload and acuity of cases requiring case management becomes the challenge. Unless you are concurrently coding, it is difficult at best to assign acuity in real time to caseloads.

Regardless of which staffing model is being used, it will always work best with the right people in the right roles.

### **Education and Experience**

#### **Registered Nurses and Social Workers**

A case management department typically has a number of different roles to match the types of functions that have to be accomplished. Those roles might include registered nurses (RNs), social workers (SWs), and case manager assistants (CMAs).

A CM position can be filled by an RN or SW. RNs and SWs who report to the same director and have similar functions may require different job descriptions. If a single job description is used for both, separate sections could be written to delineate the qualifications for each profession.

At a minimum, a candidate for a CM position should possess a basic set of work skills. The applicant must be able to communicate well with a broad range of people, including physicians, care team members, and members of all socioeconomic strata. She or he should show critical thinking skills and an ability to creatively solve a problem to come up with an action plan.

Because transition management involves clinically based assessments of the patient’s ongoing needs, it is crucial for applicants for positions in case management to have clinical knowledge in the area for which the director will be responsible (e.g., medical units, pediatrics, and behavioral health). Having clinical experience ensures that the standards of care that apply to that staff member’s patient population are considered and appropriately integrated with the transition of care.



Another critical requirement (as supported by the Centers for Medicare and Medicaid Services [CMS] suggested qualifications of a clinician doing discharge planning) is experience in a community-based setting. This type of experience will be helpful when the CM transitions patients to community-based programs.

**TIP:** A general guide on the requirements for hiring into a position of “case manager,” whether it is an RN or an SW, can be found in the Medicare Conditions of Participation for Discharge Planning (SOM, 2014).

### **Case Management Assistants**

Many organizations are using CMAs for duties such as sending faxes and making phone calls to postacute providers and transport companies. Caution should be used in establishing such roles. When all CMs depend on a small number of CMAs to perform tasks that are critical in discharging the patient, bottlenecks could form.

A more effective way to use CMAs is to use them as CM “extenders.” Many problems arise at the end of the day when a patient is waiting for a ride home or a signature on a form to complete the discharge. These extenders can make sure nothing is missed and no patient is kept overnight unnecessarily. Some hospitals have utilized CM extenders to work evening hours that overlap with the end of the day for the CM staff. The CM extenders support the work already done to make sure that the patient has a smooth transition home, no matter what time of day. They can set up ambulance transport, complete paperwork, and clear any other obstacles. They can also proactively prepare patient discharges that are to occur the next morning.

**TIP:** A well-trained and supervised administrative staff member in the role of case management assistant can facilitate communication and documentation and free up licensed.

**TIP:** During the recruiting and interviewing process, the director is encouraged to work closely with the human resource department. The interview process is highly regulated, and human resource can help the director understand the Department of Labor Fair Labor Rules (DOL, 2014). Valuable candidates should never be lost due to a lack of understanding of basic regulatory requirements.

### **Metrics**

To the extent possible, verifiable metrics should also be part of the evaluation of a transition management team’s performance. For unit-based teams, those metrics might include patient satisfaction scores in relation to transition of care, overall patient satisfaction scores by unit, and, wherever possible, comparisons of those results to those of other units. Readmission rates by unit are a valuable metric because risk-adjusted readmission rates apply.

Many software systems are available that can help track metrics. If directors do not have automated data available, consider using a checklist and spot checking documentation throughout the year. Conducting random medical record reviews for timeliness, complete entry, and adherence to department standards/policies will give insight into how well an individual CM is not only carrying out the functions of the role, but communicating important information to others. Be sure to seek feedback from other hospital departments, as appropriate, regarding individual performance.

### **Scheduling Work**

Scheduling staff in a case management department requires creativity, flexibility, and a shared understanding that the needs of patients come first. There are many variables that make scheduling challenging. Some, like planned time off, the need for cross-training and how best to use part-time staff can be considered in advance. Unplanned absences, whether from a short-term illness or maternity leave, are unpredictable and can be hard to cover and might require some creative scheduling.

Always keep in mind the impact the work schedule has on your staff and that, when possible, a little flexibility can go a long way. Sometimes, employee satisfaction depends on it. Get your staff involved in the planning. The people who do the work often have the best ideas about how their work should get done on holidays and during vacations. Splitting days and cross-training are just some of the options that could be considered. Having a plan in place with clear expectations is key.

Work hours must also meet the demands of the particular area or function being covered. You have to take into account the different patient populations and transition trigger points. It does not make sense for a CM working on a surgical unit to arrive late in the morning after the surgeons have already rounded and moved on to the operating room. Staff that work on a unit where therapy is not completed until later in the day or where the physician is not rounding until after clinic hours would do better to come in later and be there when new information is available.

### **Department Cross-Coverage**

Covering absences—both planned and unplanned—across units (and in larger systems across different facilities) is one of the constant and unpredictable challenges directors face. The director must be able to cover the absence of an assigned CM, even if that absence is in another unit or facility. A staff member assigned to one unit, such as medical-surgical unit, must be able to cover an absence that might come up unexpectedly on the orthopedic unit, pediatrics,

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behavioral health, an outpatient or specialty clinic, or the emergency department (ED).

In many situations, directors must make quick decisions about coverage. To make those decisions easier, the director can take action in advance, like setting up planned rotations. The ED is one area you do not want to leave without coverage. If you cannot put someone in the ED full time, consider rotating a staff member through on a daily basis.

Also, have a good idea in advance of which areas are highest-risk and highest-impact. Which areas impact readmissions? Are there areas that have a high need for managing the resources consumed, or have a high need for transition management, or linking with community resources?

### **Working With Other Departments and Functions**

#### **Emergency Department Case Management**

Patients in the ED can often use case management or social work services, but the ED staff might be reluctant to call for those services if they believe it will delay the patient's discharge from the ED. You can be proactive and address this issue. Provide a short list of patient types that might come through the ED and would benefit from case management or social work services. Offer short stand-up meetings to educate ER staff on the specific services your staff can offer patients. Be prepared to provide expected response times and to show that even if it takes a little longer, a good discharge plan can avoid a readmission.

Above all, build a strong and productive relationship with the ED staff and physicians. Make sure they know you and the members of your staff and what your department can do to support them. Work closely with the ED director to determine whether there have been admissions that could have been avoided if the patient had been discharged from the ED with some placement assistance. EDs afternoon and evenings are generally a good starting point for coverage. Assigning staff to the ED must be done taking into consideration the needs of the inpatient census. Staff from inpatient units may be assigned flexible time schedules to work into late afternoon or evening hours in the ED. Doing this takes

consideration of case-loads for the staff's usual assignment. The director may choose to do a short-term pilot of assigning staff to the ED to identify the value of the trade-off of coverage.

### **Physician Advisors**

Physician advisors can be an extremely valuable resource for directors and CM staff, but it is important to agree in advance on the scope of work that a physician advisor might expect from your staff. That way your team will always know what to do and what is expected when an advisor calls. Whether it is secondary reviews only or interventions with medical staff, the expectations must be understood and respected for all involved, including both hospital and physician staff. If the assistance is expected to be more time consuming, such as participation on committees or making recommendations to improve clinical documentation, it is important that you understand in advance how much time is required so you can consider that work in your budgeting and scheduling.

**TIP:** Advocate for organizing a physician advisory program that meets the specific needs of the hospital patient population, the CMs, and the department as a whole. Network through the National Association of Physician Advisors (NAPA, 2014) to share information and discover best practices from industry leaders.

### **Policies and Procedures**

- Policies and procedures can provide much needed structure and standardization to the case management department. By stating clear expectations and educating staff, you can avoid some inconsistencies in practice.
- Hospital policy dictates the process for development, maintenance, and updating of your policy and procedure manual. The following policies should be considered as a suggested minimum.

### **Leaving Against Medical Advice**

Hospitals generally have a policy to address the situation where a patient chooses the option of leaving against medical advice (LAMA or AMA). The case management department should have its own policy to provide guidance for handling LAMA patients who have been identified as needing posthospital services. A policy written in collaboration with the medical, legal, and risk management teams should, at a minimum, address the following for any LAMA patient:

- Should the CM assist the LAMA patient in obtaining ordered prescription medication?
- If the patient needs it, should the CM assist with transportation, especially if the department has funds to pay for cabs for patients who have been medically discharged?

- If the patient's physician has written an order for home health services, should the CM send documentation to the agency for start of care?

Once a policy is agreed upon, the director is responsible for making sure it is followed consistently by all case management staff and that specific transition management documentation is entered into the medical record. The documentation should follow the facts in the department policy regarding managing transition for patients who leave against medical advice.

### **Documentation of Patient's Discharge Status**

An insurance claim for a patient's episode is not complete until a disposition status or code is selected and entered. Which code is entered is a key piece of information for the billing department that could impact revenues for both the hospital and the postacute facility. For example, when a patient is discharged earlier than the standard length of stay for selected Medicare severity diagnosis-related groups (MS-DRGs) and transitioned to a skilled nursing facility, or other level of care covered in the transfer DRG rule (HFMA-NC, 2012), the hospital claims department will enter a claim to Medicare using a different coding formula than if the patient's length of stay was for the entire predicted MS-DRG stay. Not having the accurate code can lead to a delay in payment.

Because other staff may be involved in coding, it is important to have a policy that identifies the CM as being responsible for selecting the discharge status code. Training staff on how to document discharge status codes should also be addressed, either in this or a related policy.

### **Documentation of the Discharge Process**

The process by which patients who need case management are identified as well as the length of time within which they will be evaluated should be documented. Will it be 24 hours? Within 2 business days? Guidelines for documentation should be addressed as well. Methods of documenting the discharge planning process are as multiple and varied as the many different formats are available for medical records. CMs, be they nurses or SWs, should document progress on the discharge plan using the same format as do physicians and other clinicians involved in the patient's care episode. Using a common format for communication, among all health professionals involved in the care of a patient, facilitates the flow of information and contributes to that patient's safe and efficient discharge. Although checklists, critical pathways, or other tools are useful for monitoring the process, the core communication in the transition of a patient should still be notes describing the patient's status, response to treatment, concerns, and next steps.

### **Documentation of the Utilization Process**

UR is a function separate and distinct from discharge planning, and a separate policy to address it should be written and maintained. The policy should provide guidance on where CMs document the review of utilization of services findings. It should also state whether the utilization worksheets or forms, or narrative findings, are maintained as part of the patient's inpatient medical record or in a separate location. Because the reviews done by staff may have a direct impact on the patient's transition plan of care, documentation must reflect that the review information was used as a resource to make a discharge plan, but that the hospital still has the obligation to provide a safe and complete discharge plan.

### **HIPAA Title II—Consent for Treatment**

When a hospital refers a patient for posthospital services and, as part of the discharge planning process, sends that postacute provider a packet of patient information, that referral is considered a treatment under Health Insurance Protection and Accountability Act (HIPAA) Title II Privacy rules. The information transmitted is considered protected personal health information (PHI) and is subject to an array of privacy rules and regulations. Violations of these rules can have serious financial consequences for the hospital, so the case management directors must be aware of these rules and how the department is "using" (vs. disclosing) PHI. Directors should work with the hospital administration to make sure that the consent for treatment form that patients sign on admission covers the "use" of actions by CMs in making referrals.

**TIP:** Directors and administration should review the full information on this section of HIPAA as part of the OCR (Office of Civil Rights) when writing consent for referral policies (OCR-HIPAA, 2014).

### **Discharge Planning Rounds**

Making "rounds" on nursing units has become an essential activity for transition management. They are a valuable tool in collaboration and in tracking patient progress—or lack of progress—in the discharge plan, in identifying barriers or in determining that the plan can be implemented sooner than expected because of the patient's progress.

A policy, or protocol, is important so that there is consistency in how rounds are conducted from unit to unit and day to day. The director should set the tone for how rounds are conducted with guidelines for the following points:

- What is the most efficient timing and frequency of rounds—morning, afternoon, and daily?
- Who leads and who attends? It could be CMs, physician advisors, staff nurses, therapists,

pharmacists, dietitians, or other clinicians on the basis of the type of unit.

- What methods can be used to keep the discussion focused on “transition topics”?
- How can the group determine if an individual patient care conference is needed?
- How are the findings, actions, and plans documented for each patient?

The director must have a plan for what happens to rounds when a CM is off work and the patients are being covered by another CM, whose rounds may be at the same time. Skipping rounds and losing the pace can lead to a loss of momentum and, over time, reduce the value of rounds. A frequently asked question is about the location of rounds. There are multiple possibilities. They can be conducted while “walking,” in the hall, at each patient’s bedside or in a conference room (Holldand & Hemann, 2011). The choice of types of rounds can vary depending on the unit, but the method should be consistently applied and guidelines of the department followed.

### **Staff Education by Potential Referral Sources**

Guidelines for staff education provided by potential referral sources (also known as vendors) should be written with input from the hospital compliance department. Representatives from posthospital providers of care are among some of the best sources of education for staff members about those settings. But the director must also be mindful of privacy concerns and the potential for marketing to staff or attempting to steer patients to one vendor over another. A clear and public policy must be in place describing how vendors must provide a balanced education or in-service program for staff without marketing or suggesting one vendor over another. Details of the education, such as the venue (on-site or off-site), whether it will take place during working hours, whether meals can be provided, whether continuing education credit process is expected, how often an agency or organization can provide education, and whether there are certain restrictions on the content should be clearly laid out in a policy or procedure and cleared with administration. This is particularly important if a hospital owns posthospital providers, so that there is a balanced education program.

## **Track 2: Compliance and Accreditation**

Compliance and accreditation are sometimes considered separate entities, but they are not. Accreditation standards, regardless of how the hospital decides to attain that status, are based on the rules and regulations that apply to payment and practice for hospitals.

There are many standards that overlap across multiple hospital departments, such as those related

to patient safety, privacy, and quality. The case management director contributes to the organization’s broad effort to meet these standards by making sure the department is in compliance. Regarding DP and UR standards, however, the director bears sole responsibility for compliance on behalf of the entire organization.

In some organizations, DP functions are carried out by one team and UR by another. The two functions sometimes reside in the same department and sometimes not. The authors recommend that these two primary functions be assigned to the same case management director because there is a significant congruence between them. Admission, continued stay, and readiness for discharge flow across discharge planning and UR naturally and easily are understood by all staff and patients.

The federal rules that organizations must comply with originate in organizations and agencies that follow a logical pattern. The Department of Health and Human Services (HHS) is a division of the Federal government with responsibility for the CMS. The CMS administers the Medicare program, providing health care security and choice for the aged and disabled in this country. The CMS administers the Medicaid program and the State Children’s Health Insurance Program jointly with state governments. The CMS is a division of Health and Human Services whose rules and regulations are driven by Congress. The OCR—Office of Civil Rights—is also a division of HHS that administers the HIPAA (Title II Privacy).

Rules/regulations (HIPAA, patient rights, patient choice) about patient choice and rights must be understood by all staff who participate in discharge planning. Understanding the rules will help the staff apply the rules where appropriate.

HIPAA/patient choice/patient rights are issues that your staff must be vigilant about in all circumstances. The policy must be made easy to be compliant. Every patient has a right to choose among available and appropriate providers, matched to the patient’s level of care, geographic region, payer, and availability (Birmingham, 2009). It is required to give a patient/family a list of available and appropriate postacute providers. This list should be maintained department-wide, and this can be accomplished by avoiding having each staff member maintain a list. There are no rules on how to maintain an up-to-date list, so the director must ensure that there is a policy or protocol on how to maintain an up-to-date list. There are tools to automate lists of providers, such as publicly available databanks, or commercial products that provide access to lists. Whatever the method you use, be sure it is used consistently by all staff members.



One practice to avoid is to not let providers fax you who has an open bed every day; by the time it is received, it has probably changed, and access to the information is limited to the location of the fax machine and not useful to staff working with patients.

### **CoPs and CfCs**

The CMS develops conditions of participation (CoPs) and conditions for coverage (CfCs) that health care organization must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. The CMS also ensures that the standards of accrediting organizations recognized by it (through a process called “deeming”) meet or exceed the Medicare standards set forth in the CoPs/CfCs (CMS COP, 2014). The CoPs apply to the entire hospital and are not broken out into departments, but rather listed by “basic functions” that indicates that if a hospital (or other type of organization) intends to provide services to federal beneficiaries (Medicare and Medicaid), the organization must follow the CoPs.

For Subpart C Hospitals, short-term acute care, the basic functions that are primarily carried out in the case management department are UR §482.30 and Discharge Planning §482.43.

The director must review all of the basic functions for the organization so that there can be a strong collaboration and accountability for meeting these minimum standards. The current, updated regularly, CfCs and CoPs are located in electronic format at the Electronic Code of Federal Regulations (CMS, 2014b).

Translation and Interpretation Services (Federal Coordination and Civil Rights Division, 2002) standards are based on Executive Order 13066. These standards pose a significant responsibility on the director because the plan for transition involves in-depth, detailed, frequently emotionally charged, and difficult decisions made by the patient and the family.

The need to plan for translators must be proactive. Not having the appropriate interpreter at the time when clinicians, the family, and the patient are available can hold up a discharge or worse, end up with a plan that is not well understood by either party.

Executive Order 13166 on Limited English Proficiency (LEP, 2000) is clearly written with standards including which type of language service to employ and the expectations for compliance. There are many phone services available to be considered as an alternative as well that provide immediate access to an interpreter 24/7. Some hospitals utilize double phone set connectors at the bedside that allow the physician or the CM, the patient, and the interpreter to all be on the same line at the same time.

“Beneficiary notice initiatives” (BNI) is a term used by the CMS to provide information about financial liability (CMS BNI, 2014). Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service Medicare and the Medicare Advantage Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. Some of these notices include the Advanced Beneficiary Notice (MLN/CMS, 2014); Hospital Issued Notice of Non-coverage (HINN), and the Hospital Discharge Appeal Notice—the Important Message (IM) from Medicare.

The distribution of beneficiary notices is usually under the jurisdiction of the UR committee because of the “financial” issues related to when the notices are issued. Other than the “IM,” which is mandatory for all Medicare beneficiaries, the other types of notices are used when a situation arises in which the financial coverage or responsibility needs to be explained to the beneficiary in specific terms. The director must be aware of situations in which a notice is required, and work with UR to deliver the notice and document that the notice was delivered; hospital policy on where to document these notices should be written in cooperation with the UR committee.

Because delivering a notice to a hospitalized patient is difficult, the director may want to do scripting for staff. Role-play and talk through scripts before administering is helpful. The director may choose to accompany the staff for first few or if they need back-up, or for predictably difficult patient situations. Have more experienced staff mentor new staff. Staff should be reminded that the impact of a notice can be affected by how the message is delivered. Encourage staff to provide an explanation in easy to understand language, where the patient and the family can get more information, or how to appeal, but it is very important that staff should have a calming, not inflammatory, presence.

The CMS approves different agencies for accreditation and awards “deemed status” on a contract basis. This means that if your organization is accredited by one of the deemed agencies, you must follow the standards of those organizations, which at a minimum follow the CMS Interpretive Guidelines.

As a director you are involved in the process of accreditation and should have knowledge about which accreditation organization, if any, contracts with the hospital. The Interpretive Guidelines published by Medicare may be used as a self-screening tool, but you must also be aware of any of the additional standards the accrediting body uses—accreditation by deemed organizations such as TJC, DMV, or AOA, or by state surveyors.

Hospitals have the option to have a direct survey of compliance to the CMS standards. This means that the state in which the hospital is located will survey the hospital directly, using the CMS Interpretive Guidelines, State Operations Manual (CMS, 2014d).

### **Track 3: Discharge Planning**

Discharge planning is the most patient-centric function for which the case management director will be responsible. In Track 2 on compliance and accreditation, we presented the rules that drive the discharge planning process. Track 3 offers guidance on how to operationalize the work needed to meet the discharge planning standards.

### **Selecting an Operating Model**

The director is in the unique position of being able to design the discharge planning workflow. A successful and workable design will influence not only how patients are discharged but how effectively the department meets all required rules and standards. There are many different implementation models available, although most fall into one of two categories: centralized or decentralized.

A centralized model is recommended when a step or a set of steps can be selected from the discharge planning process and funneled to one team, especially when any of those steps are complex and can benefit from the singular focus of a dedicated team. A good example is ambulance transportation for discharge, which has a great number of details that need coordination. Assigning and arranging transportation services to a centralized team improve coordination, avoid missed rides, double booking, or the wrong type of staffing by the ambulance company.

A decentralized model is frequently used when all the steps in a patient's discharge are managed by one CM, including assessment of the patient's needs, working with the members of the interdisciplinary team, arranging transportation, making referrals to postacute care providers, and arranging for equipment or medications. The benefit of this approach is that the CM knows the full history of the patient's hospital stay, including any special needs or requests, and has interacted with the patient's family. A single point of contact can also benefit all involved in the case and make communication easier.

The director needs to work with the department and other related departments, to determine which implementation model works best for the organization. Variables to be considered include the patient population being served, available resources and the structure of the organization, and how it fits with the hospital's broader organization.

Regardless of which model or combination of models is selected, what will make it all work is teamwork and communication. To prepare a safe and effective discharge plan, the CM must interact, face to face, with the patient. That is a given. Also required is the means and ability to interact with other professionals and responsible persons across the hospital. Even though discharge planning is a distinct function, the collaboration of departments such as clinical services, SWs, medical staff, and diagnostic services, to name a few, all play important roles in the process. Many directors have a scope of responsibility that goes beyond the case management function, which can make communication and collaboration across teams easier. Also useful is a software system that can deliver real-time information to both internal and external contacts. No matter where the various functions report, the director should chair a meeting at least quarterly with members of all departments who touch the discharge planning process. Topics to discuss might include trends and patterns, internal barriers, and reports measuring readmissions that can be tracked to discharge planning services.

### **The Four Steps in Discharge Planning**

There are essentially four steps in the discharge planning process (CMS COP, 2014): screening, assessment, planning, and implementation of the plan. In this section, the authors offer practical information about specific factors within the four steps that are most problematic for directors.

### **Screening**

Screening is an important function that has an impact on the discharge planning process. In the most recent COP (CMS COP, 2014), the concept of screening all patients for transition of care is clearly stated. Hospitals may choose to have specific criteria for screening, for example screening by age or diagnosis, instead of screening all patients, but hospitals must have a mechanism to screen everyone for the purposes of transition of care.

The method used by hospitals to screen an admitted patient for potential needs must be agreed upon by all staff that care for patients. Coordination of the department of nursing, the case management department, and their respective policies, in particular, is important for screening patients for discharge needs. The only sure way to screen every patient is to enlist the nursing staff in the initial assessment. With around-the-clock staffing, nurses are available for patients admitted at any hour or day of the week.

The initial assessment tool that the department of nursing uses must be designed to include items that can be used to identify a patient's potential need for post-hospital services. As an example, a staff nurse could

follow this line of questioning in an assessment as a way of gathering information for discharge planning:

- What preadmission types of services was the patient receiving, if any, and what may have gone wrong, resulting in this current admission?
- What care needs were being met by the patient's family that will need additional evaluation and support?
- How was the patient managing, or not managing activities of daily living and instrumental activities of daily living before admission?

### **Patient Choice**

One of the biggest challenges a case management director faces is the requirement to provide patients with a choice during the transition of care process. This element of the discharge process is highly regulated, and failure to comply can have significant consequences for the hospital. For that reason, the hospital's policy on managing patient choice should be detailed, comprehensive, and clear in terms of expectations.

The driving principle of patient choice is that the patient being discharged is afforded the ability to select a postacute provider from among appropriate and available options.

The term "appropriate" means that the next level of care selected by the physician, in collaboration with the other members of the care team and the CM in particular, will be able to provide all the medically necessary services required by the patient, such as clinical and rehabilitation, equipment, pharmacy, and dietary. It also means that the geographic location of the patient's next level of care has been identified. The term "available" means that the providers identified as appropriate within the defined geographic boundary have been filtered so that only those with a bed or services for the patient at the time of discharge are presented.

### **Physician Involvement in Discharge Planning**

Discharge planning is focused on the patient's need for medically necessary care after discharge, including which level is most appropriate for the patient during the course of treatment. The CM is actively involved in the transition planning with the multidisciplinary team. In collaboration with the team, the physician determines/orders the appropriate level of care, services required, and the timing of discharge.

It is the case management director's responsibility to make sure mechanisms for physician involvement in transition management are clearly outlined and that physicians understand their role in the process.

**TIP:** The American Medical Association provides multiple references and resources that the director may use to work collaboratively with physicians, in particular work done on their opinion related to a safe discharge (AMA, 2012).

### **Financial Relationships**

When providing patients a choice among appropriate and available postacute providers, the patient must be informed of any financial relationship the hospital has with that provider (BBA, 1997). The case management director determines which, if any, of the hospital's network of relationships meet the standard for financial disclosure. In some organizations, use of the term "network" implies that the postacute provider, such as a skilled nursing facility or Home Health Agency, has a working relationship with the hospital, but does not necessarily imply a financial relationship. In other areas, the term "network" implies that the postacute provider is in a contractual relationship with the hospital. The determination may be made by checking with hospital administration. The financial services department of the hospital maintains a listing of financially related entities because it is reportable to the CMS.

Because financial relationships change over time, the director must do regular reviews to determine whether existing financial relationships with postacute providers are still in place and whether new ones have formed.

*Note:* The authors are unaware of any other legal restrictions on making referrals to providers with a financial relationship. The director must examine other aspects of these referrals on the basis of the organization, state, county, or other patient protection rules that currently exist.

When a hospital has financial interests in postacute providers, or vice versa, then the referral process has an impact on the business interests of the hospital. This specific situation is referred to as "network leakage" or, more recently, the use of the term "network kepage" (William & Faber, 2014). Network leakage occurs when a referral that can be made to a postacute provider in which the hospital has a financial interest is instead made to another—and sometimes competing—provider. Network leakage can occur when a staff CM mistakenly believes that making a referral to an owned entity somehow violates a patient's right to choice. Education of CMs that the guiding principle of making referrals in this situation is that the patient be informed of the financial relationship, and that the owned entity may be the best available and appropriate service.

The director must also ensure that the CMs know the difference between the hospital's financial relationships with postacute providers, as distinguished from a physician's. There is a rule about this specific situation known as physician self-referral (CMS, 2014c). The responsibility for monitoring physician referral practices belongs to the medical staff office, and not necessarily the case management department, but it is good practice for the director to make sure that staff knows the difference between the hospital's financial relationships with postacute providers and a

physician's. Of course, not all referrals by a physician to an entity in which she or he has a relationship are improper. A legitimate reason might be if the physician is attending at a skilled nursing facility that has a therapist specializing in a particular joint replacement rehabilitation protocol.

If a CM working on a discharge plan has questions about the appropriateness of a physician's referral, the CM should discuss the referral objectives with the physician first. If the concern still exists, the concerning situation should be escalated to the director. If upon, reviewing the specific patient situation, the director also has questions about the appropriateness of the physician-directed referral, the director should explore the circumstances with the physician, and if the circumstances are not resolved, the director should refer the situation to the hospital administrator responsible for the case management department.

### **Patient/Family Refusal of Discharge Planning**

Patients and their families have the right to refuse to participate in the discharge planning process. That does not mean, however, that a discharge plan should not be made. This situation is sometimes referred to as "staying against medical advice," the opposite of "leaving against medical advice." (Jonathan R. Moran, 2010;12(6))

Patients may be encouraged to discuss the reason for refusing to participate in the planning process. Although their input might be helpful, it should not keep the CM from developing a discharge plan, with or without the patient's involvement (CMS COP, 2014).

Medicare patients have the right to appeal the discharge plan through the mechanism of the Important Message from Medicare (CMS BNI, 2014). Other patients and families also have the right to refuse to participate and appeal the plan on the basis of the hospital policy for discharge planning.

The director should assure that staff is aware of how to manage these situations without appearing to force a plan on a patient or family. The staff should escalate these situations to the director, physician advisor, or other administrative staff member if it cannot be otherwise resolved. In a few extreme situations, the director may choose to involve the hospital legal department in support of efforts to discharge the patient who has been determined to be medically ready for discharge. Facts involved in the refusal and the patient's and family's responses must be documented to avoid the appearance that the patient's wishes were not considered.

### **Release of Information After a Patient Is Discharged**

The information about a patient that is shared with a postacute provider before acceptance should be sufficient to ensure that the patient is discharged or transferred to the most appropriate level of care, and

that the start of care at the next level is well coordinated. Developing standard core content for referral packets by the level of care can eliminate variance and decrease requests for further information by providers.

In some situations, after a patient has been referred and discharged, a postacute provider may call the CM to ask for additional information. If the patient has been discharged, requests for medical information must go through the medical record department, sometimes referred to as health information management (HIM). This process will ensure that the release of a discharged patient's information follows hospital policy. Because of the need to ensure start of care or to communicate information such as laboratory tests that are completed after discharge, the director should work with the HIM department to determine the best way for a CM to comply with a request for information by a referred and booked postacute provider.

The director should monitor the requests for information after discharge to determine whether the content of the initial referral packet of information is meeting the needs of the referred postacute provider to care for the patient as soon as required after discharge. Initiating the start of care by the postacute provider depends on having accurate and complete information. As part of the review, the following questions can give the director information for further action:

- What information is requested most frequently?
- Are CMs sending essential information?
- Is there a correlation between readmissions and the type of information that has not been initially sent with patients?

The director should also work with the HIM and laboratory department to ensure that tests pending at discharge (TPAD) are monitored and, if applicable, sent to the referred postacute provider. Many hospitals have arrangements to send the TPAD to the ordering physician, but this may delay the information getting to the physician managing the postacute care (Stacy & Walz, 2012).

### **Outreach After Discharge**

Follow-up contact with discharged patients has been shown to have a positive effect on readmissions and patient satisfaction (Bermer & Panjamapirom, 2014). Many hospitals have special programs that include contacting patients after discharge. Some of these programs are managed from the case management department.

There are a number of different types of patient outreach that can be performed. Because patients frequently contact the discharging CM for assistance, it is a good idea for the Director to be aware of and prepared to manage all of them. For example, if a patient calls the CM after discharge for assistance in implementing the plan, how is the contact recorded? Understanding



the volume and nature of follow-up calls might also identify areas for improvement in the operation.

- Is there a pattern of calls related to a particular unit—a particular CM or a particular physician?
- Was the patient prepared and educated to carry out the discharge plan?
- How many times in a week do individual CMs get calls? Does this impact their inpatient work assignment?
- If the hospital has a separate outreach program, and someone other than the CM is calling the patient, how are callbacks coordinated with the callout to the patient? Is the patient getting the same message?

### **Disaster and Recovery Plans**

Hospitals are required to have “disaster and recovery” plans and protocols in place that take into account the HIPAA privacy rule and ensure uninterrupted compliance (OCR, 2014). Case management directors can have important input into the design of a plan and how it should be implemented, especially when a disaster results in the need to move patients out of an at-risk hospital, either on a large scale or a relatively small scale. Determining the type of situation that is treated as a “disaster” will help the director determine the appropriate action. Overcrowding in the ED because of a backup of patients who are ready for discharge or the need to evacuate an entire hospital because of a natural disaster are two examples of disasters. For these and other cases like them, the disaster and recovery plan should provide a list of available external resources that can provide the type of care that might be needed by patients in a disaster. In a true disaster, state and federal agencies take command of patient evacuation. Because part of a case management department’s function is to track patients’ progress to discharge, the director should have real-time information to use in determining which patients can be transitioned first, with the least risk possible.

### **Track 4: Utilization Review and Utilization Management**

Another responsibility of a case management director that stems directly from a regulatory requirement is UR. UR is a retroactive function: looking at care after it has been delivered. A director can use the information collected during the review process to manage the workflow and identify opportunities to improve processes. Turning the data collected in UR into a management tool is a critical element of being a director. The guidance in the COP for UR as a mandated function leads naturally to utilization management. The collection of information to meet the UR requirements provides information that a director can use to manage the patients’ episode of care and to identify patterns of care and opportunities that improve the utilization of resources.

Compliance with the UR COP is not part of the deemed program, such as TJC for example, for hospitals, meaning that state survey agencies have jurisdiction over the UR COP for accredited and nonaccredited hospitals. Hospitals must have a UR plan in place, and directors must be aware of the plan, what review circumstances apply, and how to access the service.

Effective August 2014, the CMS has reorganized the arrangement of reviews, splitting the services of a Quality Improvement Organization (QIO) into two separate contractual arrangements. The restructured setup separates the QIO medical case review from the quality improvement work. This was achieved by the 11th SOW (Scope of Work) contract between QIOs and the CMS (CMS, 2014).

The Quality Innovation Network (QIO) will handle quality improvement and technical assistance; one to do quality improvement and the other to do the Medicare review (appeal process). This means that the director will be required to work more closely with the organization contracted for Beneficiary and Family-Centered Care (BFCC)-QIO.

There are three specific phases of UR in hospitals: Admission, Continued Stay, and Professional Services.

### **Admission Review**

The decision to admit a patient, either as an inpatient or to observation status, will follow the patient through that episode of care and anything that a director can do to ensure that accuracy will benefit the patient and the hospital. The considerations for admission involve reviewing medical necessity, which leads to addressing reimbursement requirements by both the CMS and commercial payers, and impacts reimbursement.

Physician advisors are valuable resources for decisions for, and with, the admitting physician. In many cases the ED CM can work with the admitting physician to determine the appropriate admission status of the patient. The admission to observation or inpatient status must be based on medical necessity and can initiate the discharge/transition plans being made at the time of admission. For example, if the patient’s stay converts from inpatient to outpatient, then the director must ensure that the staff initiate the process to meet Condition Code 44 requirements. Condition Code 44 is used when the patient’s admission status changes before the patient is discharged (MLN, 2012). The director must also ensure that the important message for Medicare is given to the patient who is admitted as an inpatient.

### **Continued Stay**

Continued stay reviews are basically a function of UR, but the information collected by using criteria sets and professional judgment is extremely valuable for DP. Tracking medical necessity for acute care and then predicting when the patient will be reaching

readiness for discharge provides a timeliness factor that is not available elsewhere. When the patient no longer meets inpatient criteria, a discharge plan must be ready to implement. Payers and patients depend on this time factor, as does the hospital. Directors in departments where DP and UR are done by separate staff must address the need to have constant and concurrent communication between both clinicians (Birmingham, 2008).

### **No Bed Available When the Patient Is Ready for Discharge**

The transition process involves finding an appropriate and available postacute provider at the time the patient no longer meets medical necessity for continued stay. If, after due diligence, there is no bed that meets the patient's need, the UR committee will review the circumstances, discharge planning work done, and document how the patient and family are notified and the next steps to be taken.

The CM then escalates the patient's transition plan to the UR committee physician member to determine the status. The UR member must indicate in the record that because there are no beds for the patient, the patient is assumed to meet medical necessity for continued stay. Documenting these actions will support an appeal should the patient's stay, or days in the stay, be denied.

Directors must be sure that staff is aware of the need to collaborate with the UR team member, sometimes a physician advisor, and document the efforts made (CMS, 2014d).

### **Criteria Sets**

Basing admission decisions on evidence-based criteria will improve the outcome that the right decision was made at the time and with available information. There are a variety of sources of criteria sets available, a few commercially produced, and CMS resources known as the National Coverage Determination. (CMS, 2015)

### **Denials and Appeals**

The involvement of case management in the business of denials and then appeals is an organizational decision. The term "denial" is used when a payer decides not to pay for care that a patient has received *after* the care has been delivered. The denial can be for admission, days within the stay, or the entire episode of care. The payer that denies care notifies the hospital with specifics about what is being denied and then informs the hospital on the first steps in the appeal process.

Each payer has a set of steps in the appeal process, and the director, when the case management department is involved in the appeal process, must be aware of the specific payers' expectation and the hospitals'. If the payer is the CMS, the denial and

appeal process has five specific steps ranging from redetermination to presenting the case to an administrative law judge. Directors must know how each step in the process works and how to monitor the status of each case denial (MLN, 2013).

### **External Reviews**

In the COP for UR, there is a section that describes options for meeting the UR requirements. Because of the need for expert and real-time review of admissions or continued stay, some hospitals have contracted with external review companies. Directors participate in the decision to use an external agency and must monitor the utilization and the outcome. For example, staff should be aware of when to use the external resource with specific information on the appropriate utilization of this service.

The director should track each instance in which an external review is used and under what circumstances. The financial aspects of this contracted service must also be monitored by return on investment. The director must know how much is being spent and whether it is the best use of financial resources.

### **A Critical Point**

The director must also continue to require that clinicians doing UR keep up with the information needed and not become dependent on other resources.

### **Quality Assurance Organizations: 11th SOW**

In August 2014, the 11th Scope of Work (SOW) by QIOs became effective. The SOW is the agreement between the CMS and QIOs that outline the initiatives for contract years. The 11th SOW changed the concept of the QIO to include, not only the traditional QIO work, but added a QIN (Quality Innovation Network).

A change that directors must consider is focused on the "responsibility for family and beneficiary complaint investigations." The CMS is shifting this resources (five) BFCC-QIOs, which will cover the entire country (CMS, 2014a).

At the time of the writing of this article, details were still emerging. Directors are strongly encouraged to contact their local/state contracted QIOs for more information on how the BFCC-QIOs interact with their patients and organization, particularly in the patients' rights.

### **Directors' Actions as Direct Support to Staff Members**

You cannot manage from your office. Walking the units, being visible to both department staff and other clinicians on nursing units, may be the single most important activity a director can take to learn what is going on and to evaluate staff interactions.

Whether a director should be able to manage a patient case load depends on the situation and the

needs of the patients and staff. Some directors with recent clinical experience can take a patient assignment, but this should be done with a great deal of thought. Ask the question: If the director is taking a patient assignment, who is managing the crises that lead to the need to take an assignment?

In some situations, there is a tendency to promote a competent clinician into management positions, oftentimes with little or no training or experience in the department to which the individual is assigned. This practice may result in a tendency for less experienced managers to focus on known clinical activities rather than managing the department (McConnell, 2008).

Keeping current on assessment, evaluation and the resources available to a specific population is difficult for a director who is expected to provide management services to the full department, especially during a situation in which there is need for additional staff to carry a caseload. Directors should not be expected to provide direct care, but should be expected to proactively set up a system of managing in a time of unusual situations, or crisis.

There are essential tasks that a director can take to better understand the ongoing situation and opportunities within your hospital. Showing support for the staff drives teamwork and is also an opportunity to support them as they learn. If they are struggling, ask probing, pertinent questions to drive them to the next step: "Don't just tell them what to do," "they won't learn and they may become dependent on you," and "this may lead to resentment if you constantly step in."

The director should know the metrics behind the workload; do not only look at the caseload ratio, but look at the whole picture of work to be done. Verify facts to make sure you confirm who needs someone to float over and help an individual on the basis of facts and observation. For example, look at the number of new admission reviews, the number of continued stay reviews, the number of placements, home health referrals, or requests for durable medical equipment.

The director must encourage staff to participate and work together with staff nurses, support staff and administrative staff such as unit secretaries on the units. They should be a working team member and sensitive to the flow of the unit.

## CONCLUSION FOR TRACKS 1-4

The role of director of case management is a challenging one that has responsibilities that span across the organization and across the continuum. The need to be a strong manager of staff, of systems and of processes, has never been greater. 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 one with seemingly limitless responsibilities. The article has been 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 this article as a reference to review the scope of work that is done, and use it 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.

## Implications for Case Management Practice for Tracks 1-4

Understanding the complexities of management of a case management department—big, small, or in a system—is as important as is the training and certification of case management staff. Whether you are a director or a staff member, this article demonstrates the breadth of information that is needed to provide transition management services to patients, to manage a department, to use compliance actions as a way to assess the internal processes, and to influence the financial well-being of both the hospital and the postacute provider who provide ongoing service to patients.

In Part 2 of this article, the authors will discuss Tracks 5-7, those which involve organizational collaborations, both internal and external, and how directors and their departments impact the revenue cycle and financial health of both the organization for which they work, and for those to whom they transition patients.

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**Cheri Bankston-White, RN, MSN**, is Director of Clinical Advisory Services for Curaspan Health Group of Newton, MA. She has extensive clinical experience in health care, including case management, utilization review, home health care, and emergency department. Her primary area of interest includes transition workflow redesign and automation for hospitals, postacute providers, physicians, and software integration across multiple organizations. She can be reached at [CBankston@Curaspan.com](mailto:CBankston@Curaspan.com).

**Jackie Birmingham, RN, BSN, MS, CMAC**, is VP, Emerita, Clinical Leadership for Curaspan Health Group of Newton, MA. She has extensive clinical experience in multiple settings with a focus on discharge planning and transition management. She has written several books and journal articles and has spoken nationally and internationally on the topic of case management across the continuum. She can be reached at [JBirmingham@Curaspan.com](mailto:JBirmingham@Curaspan.com).

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