Hospitals are changing, and as a result, are introducing new approaches to transitions of care as part of their case management departments. These new designs are being integrated into both small and large hospital systems and are impacting the way in which clinical care is being delivered. The rationale for change, overview of current trends and the value of accreditation within the landscape will be taken in turn.

WHY NOW?
Case management departments in the hospital setting have not traditionally been viewed as clinically important by senior executives, and as a consequence were often located in small remote offices away from the patient units. Often called “continuum of care” or “discharge planning” departments, historical examples of care management reveal a functional approach to managing the workload.

Responsibility herein was delineated by individual expertise: social workers handling post-care placements; utilization review case managers performing admission-related medical necessity chart reviews; and other case management staff dealing with continued stay reviews, denials and appeals management. While such a model remains both relevant and popular, the traditional approach has been challenged by the introduction of new regulatory initiatives and increased financial exposure for hospitals. The financial exposure is typified by increased denial rates, decreased revenues, and delayed discharges due to poor coordination and paying RAC penalties. There is often a disconnect between utilization review and timely discharge planning based on the patient’s needs post-discharge.

“HOSPITAL EXECUTIVES ARE BEING CHALLENGED WITH MAJOR CONCERNS RELATED TO INCREASING REVENUES.”

REGULATORY IMPACT OF ACA PROVISIONS
The Affordable Care Act (ACA) created the Hospital Readmissions Reduction Program in March 2010 to reduce preventable readmissions and decrease Medicare’s expenditures. On October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) launched a new program that penalizes hospitals for what it determines to be excessive avoidable readmissions. The penalties are based on the belief that hospitals should:
- Make sure that patients and families are educated about their care when they leave the hospital.
- Improve transitions of care.
- Improve discharge planning hand-offs to community providers and ensure patients receive appropriate care after they have left the hospital.

The Medicare Payment Advisory Commission (Med PAC) identified seven conditions and procedures that accounted for 30 percent of potentially preventable readmissions. These conditions are heart failure, chronic obstructive pulmonary disease, pneumonia, acute myocardial infarction (MI), coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty and other vascular procedures. Hospitals are at risk for penalties for readmissions for these conditions that are readmitted with 30 days for the same condition.

Now that CMS has launched the Recovery Audit Contractor (RAC) initiative, there are penalties and money to be recouped by the government for avoidable readmissions within 30 days of the last admission for the same diagnosis. The scope of the RAC program was initially limited to include only Medicare Parts A and B, but now has been expanded to include Part C (Medicare Advantage) and Part D (Prescription Drug Benefits).

Supporting the success of CMS’s RAC initiative to externalize costs, Medicare Managed Care Advantage Plans have implemented a similar review of readmissions. Considerations for introduction of a congruent program are currently being made by accountable care organizations (ACOs) that are taking risk for Medicare beneficiaries. ACOs, here, see the need to reduce avoidable readmissions for high-risk patients in the populations they serve.
“MANAGING TRANSITIONS OF CARE EFFECTIVELY IS IDENTIFIED AS ONE OF THE CRITICAL COMPONENTS TO REDUCING READMISSIONS AND POOR HEALTH OUTCOMES.”

GAINING CORPORATE BUY-IN
In addition to regulatory pressures, a key factor of influence mentioned earlier is the importance placed on the role of case management in the continuum of care. Hospital executives are being challenged with major concerns related to increasing revenues while simultaneously decreasing denial rates and improving patient experiences. They are coming to the realization that not every admission is the same and the case mix index will be drastically different in the next two to five years due to the new ACA regulatory requirements.

These concerns are made evident by recent actions within hospitals to redesign their case management departments with a strong emphasis on managing transitions of care. Many have done root cause analysis and quality focus studies to identify why patients are readmitted within 30 days. In response to the findings, organizations are in the process of implementing systemwide interventions to improve the discharge planning process. Integrated hospital systems and larger hospitals are leading the way with the redesigns. However, these changes may not be enough.

Considerations are being made for high-risk patients requiring social and community support services, who may otherwise be readmitted. Other hospital departments are engaging a transitions of care case management approach, including involvement across nursing, admissions, medical records, therapies, palliative care, and pharmacy and admitting physicians. To gain a broader understanding of the varied approaches taken and to gauge the common undercurrents across case management programs, descriptions of major models in popular use follow.

EMERGING TRANSITION OF CARE MODELS

   Hospital systems with two or more hospitals have set up post-discharge programs through an in-bound and out-bound call center that offers free transitions of care planning to discharge patients that have been identified as high risk where patient participation is voluntary.

A registered nurse (RN) reaches out to the patient and/or caregiver to ensure discharge instructions are understood and enroll them in the program. The RN completes an assessment with a plan of care. Nonclinical staff provide ongoing support and offer practical interventions in the plan of care, such as ensuring appointments are made, arranging transport to doctor’s office visits and outpatient follow-up tests, assisting patients with obtaining medications ordered by the doctor and following up on any post-discharge issues. These transitions of care units typically follow the patient for 30 to 45 days.

2. Readmission Case Managers (CM) Programs.
   In this model, the goal is to stabilize the patient and avoid an unnecessary readmission. A dedicated case manager is assigned to follow all high-risk patients who have met a risk score. The LACE index-scoring tool is often used to identify these patients. Utilizing telephonic and/or face-to-face outreach, the readmission case manager may be within the existing case management department or located in the hospital’s outpatient clinics or in a home care agency. Additional coordination may occur between the patient and the pharmacist, who often will engage in reviewing the patient’s medications.

3. Hospitalists-Dedicated Case Management.
   Many hospitals realize that when patients are all over the hospital it is difficult to develop relationships with doctors. Some hospitals have their own hospitalists (MDs), who act as the attending doctor for inpatients and also in select post-acute settings. As much as possible, patients are assigned to a hospitalist wing where a dedicated case manager and/or social worker complete an in-depth assessment, coordinate care and work with the hospitalists to achieve a timely discharge. The goal is to improve the patient experience, create a cohesive multidisciplinary team and document medical necessity with the appropriate plan and level of care administered. This approach provides a better hand-off to the next level of care, whether it is to a skilled nursing facility or the home setting. Patients on the unit with a specific diagnosis, such as CHF, pneumonia or MI, for example, can be offered a transitions of care follow-up program that includes extended community partners.

4. Integrated Special Needs Case Management Program.
   The move in care coordination here is toward an integrated model where the RN CM performs the utilization management review, initial discharge planning evaluation and continued stay reviews on an assigned unit – often with a social worker counterpart. In addition, the case management department as a whole uses root cause analysis and risk stratification to identify patients and caregivers who can be enrolled in a more intensive care coordination program while in the course of their hospital stay. Performance measures and outcomes are based on a more in-depth assessment of six categories and are tracked on each patient in the program. The goals are plotted against baseline measurements, and aim to lower length of stay, reduce readmissions, and enhance the patient and caregiver experience. Findings have led to the institution of enhanced offerings, like new technology that allows patients to take home their discharge instructions in a secure digital format. Many programs are developing applications for tablets and smartphones that can be provided to improve the patient experience. Like the Readmission Case Managers Program, this integrated special needs program includes pharmacy involvement in the drug therapy management of these patients prior to discharge, ensuring medication reconciliation and adherence with interventions.

5. Hospital and Provider Integrated Clinical Care Programs.
   Many hospital systems are moving toward integrated clinical networks and embedding case managers, social workers and support staff into community care teams. An example of this is currently taking place in ACOs that are capitatted for 5,000 or more Medicare beneficiaries. The hospitals and providers are looking at new ways to improve the coordination of care for patients at risk for readmission due to social issues, and integrate clinically with primary care practices. Primary care practices that agree to participate are assigned a care team. At this time, CMS currently has demonstration projects that are looking to determine if this approach is a new model for ACOs. Other types of embedded care management teams are also being proposed in provider
hospital organizations (PHOs) and independent practice associations (IPAs).

Regardless of the model that is chosen, the identification of populations where case management interventions will make a difference is imperative. Most hospitals’ case management departments are faced with increased pressure to “work smarter” and demonstrate value with sparse resources. Developing criteria for case identification is fundamental to an effective case management practice model to ensure that program interventions target at-risk populations. URAC’s Case Management Accreditation program builds upon essential program components and incorporates best practices to support and strengthen overall infrastructure in such ways as:

• Promoting use of consistent criteria for case identification to ensure that case management services are offered with consistent application.
• Establishing and monitoring case management program performance measures.
• Incorporating the use of evidence-based and clinical practice guidelines with practical application that supports program interventions for improved health care outcomes.
• Underscoring the importance of using information support systems to achieve and measure case management performance goals.
• Integrating shared decision-making principles that emphasize patients’ values and preferences for achieving self-management goals.

Case managers are positioned to make significant contributions that substantially impact prevention of avoidable readmissions and improvement of healthcare outcomes. This is achieved through proactive interactions for educating and engaging patients. Typically, when consent for case management is obtained, this provides an optimal opportunity for the case manager to establish and disclose the nature of the case management relationship. It is essential to incorporate a patient-centered and collaborative approach for obtaining stakeholder input. Additionally, this presents an ideal time for creating a climate conducive to providing “conflict-free” case management services and laying the foundation to promote informed decision-making through engaging the patient, families and/or caregivers chosen by the patient.

A thorough assessment is fundamental to developing an effective and patient-centered case management plan. Patients must be considered active participants for developing the plan of care. Executing the care plan requires that qualified and competent case managers demonstrate the ability to coordinate care, typically with an extended multidisciplinary healthcare team and community healthcare team.

As an additional component of the case management process, case managers must coordinate care for patients. Case manager competencies require clinical experience and critical-thinking skills for managing complex and high-risk patients while simultaneously assuming the patient advocate role to ensure conflict-free, unbiased and culturally competent care. Care coordination must also take into account patients’ values, preferences and their choice to self-direct care.

Mandates in the ACA are reshaping healthcare delivery and driving the need to ensure safe and effective transitions of care across settings for patients. Managing transitions of care effectively is identified as one of the critical components to reducing readmissions and poor health outcomes. Effective case management puts the patient at the center of all care decisions and is an essential driver to ensuring that patients get the right care, in the right setting, at the right time.

Outcomes measurement reporting becomes essential at the outset when evaluating the work performed and the outcomes obtained. Such standardized and validated measurement should demonstrate sustainable, measurable, transparent and consistently documented results.

IN CONCLUSION

As hospital case management models continue to evolve, care coordination responsibilities for case managers will continue to expand with an emphasis placed on adopting a collaborative approach with active participation from patients to achieve better coordinated care with quality, cost-effective outcomes. This progression will require organizations to demonstrate the value of case management programs to include measurable clinical, process and financial outcomes. A case management accreditation program builds a pathway for organizations to validate their case management program for achieving viable and sustainable outcomes.

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