Inside the Mind of the Hospital Discharge Planner

February 2015

Carolyn Swope
Analyst
202-568-7152
SwopeC@advisory.com

Harrison Brown
Consultant
202-568-7013
BrownH@advisory.com
Table of Contents

Introduction ......................................................... 3
Understanding Case Management Team Composition ....................... 5
  Case Management Team Roles Explained .................................. 5
Grasping the Discharge Planning Process .................................... 7
  Phase 1: Admission and Assessment ........................................ 7
  Phase 2: Duration of the Hospital Stay ....................................... 8
  Phase 3: Post-Acute Referral ................................................ 10
  Phase 4: Transfer to Post-Acute ............................................. 11
  Key Takeaways for PAC Providers .......................................... 12
Strategies to Collaborate with Discharge Planners ......................... 14
  The Grounds for Collaborating with PAC Providers ..................... 14
  Developing Collaboratives with Discharge Planners ................... 14
  Providing Solutions to Discharge Planners’ Core Challenges ........... 15
Conclusions ........................................................................ 19
Methodology ........................................................................ 20
I. Introduction

Securing hospital relationships is more important for post-acute providers than ever—and more challenging. Hospitals and payers are narrowing post-acute provider networks, and PAC providers should leave no stone unturned in maximizing and communicating their value.

Yet many providers are missing a key opportunity to do so: discharge planners. PAC providers often focus their efforts to develop strategic relationships on hospital executives, while limiting interactions with discharge planners to marketing liaisons. But such a limited approach fails to access the benefits that can come from deeper relationships with discharge planners, who have the greatest influence in several key areas of post-acute interest.

The case management team members are the critical players in discharge planning and referrals to post-acute care. The team commonly consists of several members—case managers, social workers, and potentially additional staff, depending on the model used—who work together to ensure a safe and efficient discharge for the patient. They identify patients who may need post-acute care, create their care plan, facilitate their choice of post-acute provider, and oversee the transfer to post-acute care.

The team’s discharge planning responsibilities result in great influence on the patient’s post-discharge destination and safety of the transfer. In fact, the team has the most informal influence with the patient and usually makes the placement recommendations for physician sign-off. A survey conducted of hospital stroke discharge planners confirmed this, with respondents identifying discharge planners as the strongest influencers of the patient’s discharge destination, relative to patients/families and members of the entire health care team.

As such, it is crucial for PAC providers seeking closer collaboration with hospitals to develop relationships with the case management team. But while the majority of providers recognize this, they typically have the wrong goals and adopt the wrong approach.

Post-acute providers commonly expect that marketing quality metrics to discharge planners will secure a direct referral stream—but this is a mistake. Interviewed discharge planners strongly support patient choice and will not direct patients based on a provider’s quality metrics alone. However, discharge planner relationship developments offer additional benefits:

- **Increased referral opportunities**: Discharge planners struggle to discharge patients quickly and efficiently, due to uncertainty on what patient types a provider can care for or to provider unwillingness to accept patients after hours. Collaborating with discharge planners to solve these challenges can increase the volumes and types of patients referred.

- **Improved patient handoffs**: Difficulty conveying critical patient information between hospital and post-acute frequently slows patient discharge or causes readmissions. Through collaboration, both parties can ensure they have all needed information for a safe and efficient discharge.
To access these benefits, PAC providers must develop an effective collaboration strategy. Interaction must provide value to the case management team, not just the post-acute provider. The case management team is extremely busy, and interactions that promote post-acute providers’ goals while not also providing any benefit to the team are unlikely to significantly enhance the relationship. In fact, several interviewed case management departments have now barred marketing liaisons from their hospitals.

As such, post-acute providers must understand the responsibilities, needs, and challenges of each member of the case management team at a referring hospital so they can effectively target their outreach and propose a valuable relationship.

This briefing draws on interviews with hospital case management staff to provide a road map for relationship development. The stages in relationship development, corresponding to sections of this briefing, are outlined in the graphic below.

### Developing an Effective Outreach Approach

- **Identify Discharge Planning Roles**: Providers should develop an in-depth understanding of the team structure. This enables focus on staff relevant to collaboration, and avoids bothering busy staff who cannot help with the area in question.
- **Understand Discharge Planner Challenges**: Providers must develop an in-depth understanding of the discharge planning process. This will enable them to understand discharge planners’ challenges and needs—a prerequisite to addressing them.
- **Collaborate to Address Core Challenges**: Once post-acute providers understand discharge planners’ roles and their needs, they can identify resources, initiatives, or information that would be of value to them.

The following sections offer guidance for post-acute providers on each one of these steps.

---

**Terminology Note: Discharge Planner**

This briefing uses the term “discharge planner” to describe staff with discharge planning responsibilities. Although the terms “case manager” and “discharge planner” are often used interchangeably, other staff members, such as a social worker, may also or primarily be responsible for discharge planning.
II. Understanding Case Management Team Composition

Post-acute providers must understand the overall structure and specific roles within the case management team to effectively target outreach. A variety of staff may be involved with discharge planning, and it is important to know which titles to look for and what their responsibilities and concerns may be. On the other hand, some members of the case management team are not involved with discharge planning, and post-acute providers should also know not to reach out to them.

Case Management Team Roles Explained

The table below provides a distilled list of common case management staff roles’ functions and tasks to help post-acute providers identify the team members likely involved—and not involved—with discharge planning at referring hospitals.

Staff are classified by role; each role has two categories of supporting tasks:

- **Core Tasks**: Responsibilities least likely to be shifted to other roles
- **Potential Tasks**: Responsibilities where assignment is more likely to vary across different case management teams

Note that many case management teams also include ambulatory team members, such as nurse navigators for specific service lines. However, because this research focuses on discharge planning at the hospital, the overview provided here includes only inpatient team members.

### Team Roles and Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Description/Function</th>
<th>Tasks</th>
<th>Common Staff Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager</td>
<td>Serves as key point of contact to coordinate care with</td>
<td><strong>Core Tasks</strong>: Develop patient care plan, navigate patient through</td>
<td>RN¹, LCSW²</td>
</tr>
<tr>
<td></td>
<td>physicians and care team; develops and documents care</td>
<td>inpatient setting, discharge planning, identify behavioral health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>plan, facilitates discharge planning</td>
<td>and social needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Potential Tasks</strong>: Measure quality measures, conduct utilization</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>review, secure pre-authorization, perform patient assessment, manage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>patient transition to PAC setting</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>Assists patient with psychosocial needs; helps patient</td>
<td><strong>Core Tasks</strong>: Perform patient assessment, assist in crisis</td>
<td>LCSW, LPC³</td>
</tr>
<tr>
<td></td>
<td>access benefits and community resources</td>
<td>management, manage behavioral health and social needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Potential Tasks</strong>: Financial counseling, insurance enrollment,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>manage patient transition to PAC setting</td>
<td></td>
</tr>
<tr>
<td>Utilization Review/Management⁴ Nurse</td>
<td>Manages business functions, particularly payer relations</td>
<td><strong>Core Tasks</strong>: Concurrent review, utilization review, payment</td>
<td>RN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>review/pre-authorization, denials management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Potential Tasks</strong>: Clinical documentation improvement</td>
<td></td>
</tr>
<tr>
<td>ED⁵ Case Manager or Social Worker</td>
<td>Assesses patients entering ED; assists in alternative</td>
<td><strong>Core Tasks</strong>: Perform patient assessment, connect non-admitted</td>
<td>RN, LCSW</td>
</tr>
<tr>
<td></td>
<td>patient placement</td>
<td>patients to community resources (including direct-from-ED PAC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>placement)</td>
<td></td>
</tr>
</tbody>
</table>

1) Registered nurse.
2) Licensed clinical social worker.
3) Licensed professional counselor.
4) Utilization review is the process of monitoring health care services received by patients to verify appropriateness of care and control costs. It is particularly used to ensure coverage of services received by the patient’s payer.
5) Emergency department.
### Additional Case Management Team Support Staff

<table>
<thead>
<tr>
<th>Discharge Specialist</th>
<th>Pre-Admission Nurse</th>
<th>Financial Counselor</th>
<th>Managed Care Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manages administrative tasks during patient transfer to PAC, e.g. faxing patient information</td>
<td>Works with patients scheduled for surgery to gather all needed information, prepare patient</td>
<td>Works with uninsured patients to identify and apply for potential coverage</td>
<td>Works for managed care plan; monitors patients enrolled in plan to ensure appropriate utilization and progress across an episode</td>
</tr>
</tbody>
</table>

### Lessons for PAC Providers

Post-acute providers can draw several lessons about the appropriate staff member for outreach from these role definitions.

1) **Social Workers Should Be a Key Contact for PAC Providers**

Managing elderly patients and PAC referrals is often automatically delegated to social workers, given their expertise in psychosocial needs and community resources. As such, when a team structure includes both social workers and case managers, social workers are likely designated the majority of tasks relevant to PAC providers' goals. In most cases, then, PAC providers should primarily reach out to social workers.

2) **Utilization Review Staff Usually Are Not a Valuable Contact**

Utilization review staff generally work solely with payers during discharge planning. Unless a PAC provider wants an update on the status of a Medicare Advantage patient awaiting authorization (which a case manager or social worker could also provide), utilization review staff and PAC providers will have little to discuss.

3) **Wide Variation in Care Team Structures Necessitates Careful Review of Individual Hospital Operations**

While these charts represent the general team roles and responsibilities, the specific models used by individual hospitals vary widely. The number of potential tasks that could be assigned to different roles indicates the overlap and flexibility in roles across models. For example, sometimes case managers are primarily responsible for discharge planning, sometimes social workers. Sometimes case managers and social workers are independent and identical and each manages discharge planning fully for their assigned patients, sometimes there are no social workers at all on a team.

To enable successful relationship development, PAC providers must endeavor to understand the specific team structure used at a referring hospital. This allows them to identify appropriate staff for outreach—as well as general areas of weakness in the team where support from PAC providers would be particularly welcome.
III. Grasping the Discharge Planning Process

Once PAC providers understand which staff members are involved with discharge planning, they must have a detailed knowledge of what discharge planning entails. Understanding the challenges and needs of discharge planners allows PAC providers to offer solutions to address them.

PAC providers should understand the entire discharge planning process to grasp the full range of ways their actions impact patient referrals and transfers and to understand how to provide value to discharge planners. When thinking of hospital discharge planning, PAC providers commonly think solely of preparation shortly before discharge, when a referral destination is chosen; however, this is only one part of discharge planning. Discharge planning is the process of identifying patients’ needs for a safe and timely discharge and creating a plan to address them. As such, it involves many tasks and competencies and occurs throughout a patient's stay right from admission. PAC providers who only focus on the point when a post-acute provider is chosen may therefore neglect many opportunities to develop productive discharge planner relationships.

The graphic below shows the discharge planning activities that typically occur during each stage of an inpatient stay.

Discharge Planning Process for Patients Referred to Post-Acute

The following sections provide greater detail on case management team members’ roles, actions, and considerations during each phase of discharge planning, followed by key takeaways for PAC providers.

Phase 1: Admission and Assessment

Admission

A patient’s inpatient stay begins with a member of the care team determining that they meet inpatient level-of-care status. Usually this decision is made by a more clinically-focused team member; however, for patients on observation status, a member of the case management team reviews appropriateness for inpatient admission daily, based on screening criteria such as Interqual.2

Many seniors presenting at the ED do not meet inpatient admission criteria: As an alternative to sending them home unsafely, the ED case manager or social worker will work with post-acute and long-term care providers to identify an appropriate setting and transfer the patient directly.

1) Physical therapy.
2) McKesson's InterQual® Level of Care Criteria is a product that assesses clinical appropriateness of patient services at different levels of care. Evaluation is based on severity of illness, comorbidities, and complications, as well as intensity of services being delivered.
Assessment

If admitted, a member of the case management team conducts an assessment of the patient (usually within 24-48 hours) to gather information to inform the care plan. This assessment is almost always a standardized set of questions, either based on existing assessment models or custom-made by the hospital to suit its needs. If a patient is admitted from the ED, the ED case manager likely also conducts a preliminary assessment, which interviewed discharge planners identified as extremely helpful.

The questions asked go beyond clinical information available in the patient’s medical record to delve into the patient’s psychosocial and financial situation. This allows the team to assess the patient’s risk level, which for elderly patients is often influenced by non-clinical factors.

The team then asks questions honing in on specific potential causes of preventable readmission post-discharge, so that the team can begin to address them early in care planning. Some case management teams even perform a separate second assessment specifically for high-risk patients.

If a high-risk patient was admitted from a post-acute provider, the team will often confer with the post-acute provider (or the managed care case manager if applicable, since they follow patients throughout the post-acute episode). This helps to provide a more complete picture of the patient’s situation and readmission risk factors.

Furthermore, the case management team member will often confer with the patient’s family or caregiver to ensure that the patient’s assessment of their situation is accurate. For example, a patient might say she is going to live with her daughter, but the daughter may feel that the mother cannot live at home safely anymore or be unwilling to take her in.

Creating the Care Plan

Once the case management team has gathered sufficient information for a full picture of the patient’s needs, they create a care plan that begins to plan for post-discharge needs and includes an expected length of stay. The care plan will include input from the hospital physician, nurse, and any other relevant team members such as pharmacists or physical therapists.

Phase 2: Duration of the Hospital Stay

The case management team then begins the complicated task of ensuring the timely and safe completion of the care plan. To do so, they must monitor patients continually throughout their stay to:

- Connect patients with needed resources on a timely basis
- Identify and proactively address new causes of potential delays in discharge date
- Ensure payment authorization for current and future services

Accomplishing these goals requires juggling competing priorities: moving patients out as quickly as possible, yet doing so safely to prevent readmissions.

Managing such an array of tasks on such a tight timeline can be very difficult. Interviewed case management expressed that they felt busy and overworked, and they noted the challenge of meeting patients’ needs, as seen in the quote to the right.

Sample Risk Factors

- Age
- COPD diagnosis
- High number of hospital or ED visits within last 6 months
- Self-pay

Sample Questions for High-Risk Patients

- Can you afford your medications?
- Are you able to get to your doctor’s appointment?
- Do you feel you could get out of your home if there was a fire?

Putting Together the Puzzle—Fast

“Everything’s a priority, and everything’s happening at once. You have to be able to flex your brain, to move in different directions at one time. You want to have the most effective discharge and meet the patient’s needs, without readmissions, within the time constraints put on by health care today. From the day they come in, we’re looking at a puzzle—how are we going to put this together for the patient?”

Case Management Supervisor, Hospital G
Monitoring Patient Progress

During the course of the patient’s stay, team members keep the patient on track for a timely discharge through daily monitoring of the patient’s progress. Team members check the patient’s EMR as soon as they arrive in the morning to see if there has been any change or escalation. Most teams then conduct interdisciplinary bedside rounds to see the patient in person and bring all staff contributing to the patient’s care together. The graphic below details the interdisciplinary rounds proceedings:

**Interdisciplinary Rounds**

**Potential Team Members Attending**

- Case manager
- Utilization review nurse
- Social worker
- Pharmacist
- Bedside nurse
- Physical, occupational, and/or respiratory therapist
- Physician
- Dietician

**Sample Topics of Discussion**

- Barriers to the discharge plan
- Clinical decisions to be made, e.g. does the patient need a PICC line?
- Identification of pre-discharge needs, e.g. diabetes education
- New medication orders
- Updates from the physician, e.g. results of a CAT scan

These rounds enable the team to ensure the care plan remains current by:

- Observing any escalations, e.g. if a patient was admitted for pneumonia and then fell and fractured his hip
- Reviewing updates from other team members
- Collaboratively discussing appropriate revisions to the care plan

**Connecting Patients with Additional Needs**

As the case management team monitors a patient’s progress throughout their stay, they identify what the patient needs to prepare for discharge or to reduce risk post-discharge and connect them with corresponding hospital resources. For example:

- Diabetes education for patients with low blood sugar
- Dietary support for patients who are not eating well
- PT consult for patients not walking or struggling to get out of bed well

**Utilization Review**

Throughout the patient’s stay, the team must ensure that the patient’s level of care remains appropriate and that payment will be received for it. The staff member designated with utilization review responsibilities reviews patient progress against designated criteria (e.g., Interqual) to ensure continued appropriateness of level of care. They will also communicate with third-party payers daily to conduct a clinical review and update the payer on the expected discharge plan. This communication helps ensure that the payer will authorize services provided.

---

1) Electronic medical record.
2) Peripherally inserted central catheter.
3) Computerized axial tomography scan.
Phase 3: Post-Acute Referral

Deciding to Refer a Patient to Post-Acute

Information gathered from monitoring the patient indicates to the case management team at some point during the patient’s stay that the patient will need post-acute care following discharge.

Often a clinically-focused team member will identify rehabilitation patients appropriate for post-acute care. PT consults are one primary mechanism; the case management team frequently asks therapists to evaluate patients’ capabilities, often based on specific risk factors identified in their assessments. For example, if a patient lives in a three-story townhouse, the therapist will ask the patient to climb steps in the hospital stairwell. If a patient cannot safely navigate their home environment, it indicates a need for a higher level of care. Alternatively, a bedside nurse may have observed specific clinical factors indicating a need for post-acute care.

However, the case management team can often simply observe that a patient will need post-acute care, based on their knowledge and experience.

Determining the Appropriate Level of Post-Acute Care

The team must then identify the appropriate level of post-acute care. Multiple inputs can influence this decision:

- **PT Recommendation:** Often therapists conducting a PT assessment will offer a specific setting recommendation.

- **Level-of-Care Criteria:** Some teams use specific level-of-care criteria guidelines, such as Interqual or a customized decision grid, to match patients to the appropriate setting.

- **Setting-Specific Restrictions:** Some settings have specific requirements for patients to be admitted or covered for their stay, e.g. the three-day inpatient stay required for SNFs or the diagnoses permitted for IRFs. Additionally, many Medicare Advantage payers will not approve patients for stays at LTACHs or IRFs. These factors limit the settings available for the case management team to choose from.

Interviewed discharge planners emphasized that they must also consider non-clinical factors in their decision and advocate for the patient’s holistic needs. As one case manager put it, “The case manager’s role is to come up with a patient-centered plan that takes everything into account.” As such, they will balance the often solely clinically-focused perspective of therapists or physicians with consideration of how a given setting might impact a patient emotionally, financially, and socially.

For example, a physical therapist might recommended short-term placement in a skilled nursing facility for a patient with dementia. But the discharge planner will note that moving a patient with dementia out of their familiar home environment and into an unfamiliar and confusing environment may ultimately cause the patient greater harm than the benefit of the setting. So the discharge planner will work with the physical therapist to understand why skilled nursing placement specifically is necessary. For example, they may ask: Could the patient’s needs be addressed by going back to their assisted living residence and receiving assistance accessing home health therapy benefits?

While physicians are involved with the referral process, the decision on appropriate post-discharge level of care is almost always made by the case management team. The team brings the physician their recommendation, which the physician will generally approve unless he or she has strong objections.

Serving as a Patient Advocate

“Therapists sometimes jump to conclusions. You may be doing a patient more of a disservice by removing them from their environment for a week or two and putting them somewhere that will confuse the heck out of them.”

“One of the things that we have to do with physicians is educate them to the patient’s goals of care and what the patient really wants. Because the physician’s focus, appropriately so, is on the clinical picture.”

Director of Case Management, Hospital C
Selecting a Post-Acute Provider

Once the appropriate post-acute setting has been determined, a case management team member will solicit the patient's choice of post-acute provider. To do so, the discharge planner will provide the patient and family with a list of local providers approved by their payer.

Discharge planners are generally highly concerned with maintaining patient choice and do not attempt to limit their list or directly steer patients towards higher-quality providers. Select discharge planners will “gently” steer patients by asking them to choose three providers and pushing for the highest-quality, or by simply leaving the poorest-quality providers off their list. However, such steering is the exception. Instead, the majority of case management teams try to ensure a high-quality experience for their patients indirectly, by:

- Encouraging the patient to look online at CMS Compare information and to visit potential facilities.
- Contacting PAC providers to let them know about problems, e.g. seeing frequent readmissions or hearing frequent patient complaints, so that low-performing providers improve.

In some cases a patient has a specialized need, such as ventilator care, that not all providers can meet. For these patients, the team will verify which providers are equipped to handle that need and explain to the patient that only those providers will be able to care for them.

Additionally, in the event that a patient is enrolled in an ACO with a preferred network, the team may limit the list to preferred providers.

At this stage, the team may encounter resistance to the chosen discharge setting from the patient and family and work to bring them on board with the plan. For example, patients are often unwilling to leave the independent home environment. A team member will break down the situation to help the patient understand the necessity for the chosen discharge setting: “Who’s going to do this for you at home? How will you access your medication?”

Phase 4: Transfer to Post-Acute

Verifying Patient Placement

Once the patient has selected their top-choice provider, the case management team must verify that the provider is clinically and operationally equipped to accept the patient.

Generally the case management team will be in contact with the chosen provider for two to three days before discharge. The team will send key patient information—diagnosis, medications, level of care needed, specialty needs—so that the provider can evaluate their ability to accept the patient. It may take some time for the post-acute provider to determine their ability to accept the patient or simply to respond, so the team will try to begin the process early.

At some hospitals, a clinical liaison from the selected post-acute provider will come to the hospital to see the patient in person. This visit has two main purposes: it allows the post-acute provider to more thoroughly evaluate the patient and provide an accurate answer as to whether they can accept the patient, and it enables early care planning and rapport building.


1) As a condition of participating in Medicare, hospitals may not restrict Medicare patients’ choice of post-discharge provider from among Medicare participants. They are “required to include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area,” without “specifying or otherwise limiting the qualified providers that are available to the patient.” After offering this comprehensive list, they “must, when possible, respect patient and family preferences when they are expressed.”
Sending Patient Information

Before the patient can be discharged, however, the case management team must ensure that the chosen provider has all patient information needed for a safe transfer. Methods of transferring this information vary: some hospitals fax the information to the provider, some grant read-only access to their EMR. Select case management teams also conduct warm handoffs by calling post-acute staff members to discuss the information in person and highlight critical information. Sample information needed is listed in the box to the right.

Discharging the Patient

Finally, the patient is ready for discharge. However, several last-minute obstacles often arise that artificially prevent discharge:

- **Lack of authorization**: Obtaining authorization from Medicare Advantage payers for the patient’s post-acute destination can be time-consuming.

- **Lack of physician sign-off**: Physician approval is required for a patient to be finally discharged, yet physicians may not be physically on the floor until some time after the patient is ready.

- **Limited post-acute admission hours**: If a patient is ready for discharge after hours or on a weekend, the post-acute provider may not have an admissions staff member prepared to accept them, and discharge will be delayed until business hours.

Key Takeaways for PAC Providers

**Key Takeaway #1: Case Management Team Is the Crucial Contact**

The case management team are the key decision-makers on post-discharge patient placement. While physicians, nurses, and other clinical staff may contribute, the case management team is more closely involved in the referral process. Physicians largely approve decisions made by the case management team, rather than determining a destination themselves, and the case management team manages all operational elements of discharge.

**Key Takeaway #2: Referrals Impacted by Capabilities, Not Quality Metrics**

Capabilities, rather than quality metrics, impact patient steering. Discharge planners are unlikely to steer patients significantly based on provider quality: while a few may gently push patients away from lower-quality providers, most have strong respect for patient choice. However, in the case that only select providers are able to take a patient, steering patients to those providers does not violate patient choice.

While the case management team is unlikely to begin directing a greater volume of patients toward any one PAC provider based on quality or relationships, they are likely to send patients to the only providers who can accept them—whether due to specialized capabilities or extended admission hours. PAC providers should therefore focus on ensuring that the team has a full understanding of their capabilities and that protocols are in place to accept patients at all possible hours.

Furthermore, collaborating with the case management team can result in safer and more efficient patient transfers. While this may not directly generate referrals, it could do so indirectly by reducing readmissions and enhancing efficiency, thereby creating a more attractive value proposition to hospital executives.
Key Takeaway #3: Discharge Planners Have Strong Need for Additional Patient Information

The case management team has a heavy focus on patients’ holistic needs, including psychosocial and financial. These needs strongly inform the patient’s care plan and discharge destination. Yet this information can be difficult to elicit from patients, who may not even realize their barriers to a safe discharge themselves. To fully understand patients’ holistic needs, discharge planners need information outside that included in the medical record, such as patients’ caregiver status and lifestyle issues.

PAC providers are uniquely positioned to provide this information for their readmitted patients or for former patients, making care plan creation easier and resulting in a safer and more comprehensive care plan. They can provide this information by:

• Sending along a form containing key psychosocial, as well as clinical, information with transferred patients
• Contacting the case management team to join team conferences and discuss causes of admission and potential barriers to a safe discharge

Key Takeaway #4: Discharge Planners Hard-Pressed for Time

The case management team wants to move patients out of the hospital as quickly as is safely possible. As such, they are extremely busy, and they need rapid responses and turnaround from other staff and from post-acute providers.

When a patient is ready for discharge after hours or on weekends but a PAC provider does not have someone on duty to accept admissions, or when the discharge planners cannot reach any admissions staff and must wait to be called back, length of stay for the patient increases unnecessarily.

PAC providers can support discharge planners in facilitating a timely discharge by:

• Offering 24/7 admissions
• Providing a direct cell phone number for an admissions contact
• Responding as quickly as possible to referrals

More information on the resources, protocols, and initiatives suggested here is provided in the following section.
IV. Strategies to Collaborate with Discharge Planners

The Grounds for Collaborating with PAC Providers

Collaboration with the case management team is important to PAC providers—and the good news is that it is important for the case management team as well. Post-acute providers are essential partners in achieving case management team goals of moving the patient out of the hospital as quickly and safely as possible. The graphic below details how collaboration with PAC providers helps to support these goals:

Areas for Case Management and Post-Acute Collaboration

<table>
<thead>
<tr>
<th>Discharge Planner Need</th>
<th>Reduce Length of Stay</th>
<th>Reduce Readmissions</th>
<th>Improve Referral Convenience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Accepting patients immediately upon readiness for discharge</td>
<td>• Gathering information on patient’s background to inform hospital care plan</td>
<td>• Easing ability to contact PAC provider staff</td>
</tr>
<tr>
<td></td>
<td>• Avoiding last-minute patient rejections</td>
<td>• Improving transfer of patient information</td>
<td>• Simplifying process of verifying provider ability to accept patient</td>
</tr>
</tbody>
</table>

The case management team cannot make improvements in any of these areas without the participation and buy-in of PAC providers.

As such, all case management teams interviewed by the Advisory Board had developed initiatives, programs, and meetings with local PAC providers to reduce readmissions and improve the safety and convenience of patient transfers. The teams universally expressed enthusiasm about such collaboration and found the outcomes beneficial.

Developing Collaboratives with Discharge Planners

Creating avenues through which the case management team and PAC providers can communicate and understand each other’s challenges is the first step to solving those challenges. Most case management teams form regularly-meeting collaboratives with their main referral partners, attended by key staff from both the case management team and the PAC provider, to serve as this avenue.

Specifically, PAC providers can use such collaboratives to solve discharge planner challenges by:

- Soliciting a better understanding of discharge planner needs
- Discussing their barriers in meeting discharge planner needs
- Brainstorming mutually acceptable solutions to challenges, including support that each party can offer the other
- Sharing best practices, e.g. around reducing readmissions, with one another to better address discharge planner needs

Discharge Planners Enthusiastic about Collaboration

“I love that we are working with the nursing homes.”

Case Management Supervisor, Hospital G

Typical SNF Collaborative Participants

<table>
<thead>
<tr>
<th>Hospital Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case managers</td>
</tr>
<tr>
<td>Director of Case Management</td>
</tr>
<tr>
<td>Nurses</td>
</tr>
<tr>
<td>Social workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SNF Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative-level staff</td>
</tr>
<tr>
<td>Admissions nurses</td>
</tr>
</tbody>
</table>
Interviewed case managers found that once they had begun meeting with PAC providers, addressing their issues became extremely easy. After all, both parties have the same goals of sending patients to post-acute care safely and efficiently. Clashes and frustrations with one another were generally due simply to a lack of understanding of each other’s barriers and needs—for example, hospitals having no conception of the logistical hurdles to SNFs of offering 24/7 admissions—which each party could help the other with to further mutual goals.

As a result of the teams’ new awareness of the barriers that post-acute partners faced in reducing readmissions and improving transfers, they expressed flexibility in helping them address those barriers in return for PAC providers’ support.

As such, PAC providers should view these collaboratives as a true opportunity to jointly develop effective solutions to improve the quality and efficiency of care, not as a marketing opportunity.

While only a few PAC providers may be included in such collaboratives at first, the collaboratives generally expand over time as additional providers express interest and the team finds them to be effective. So providers who are not currently included should be sure to approach the case management team about participating.

Providing Solutions to Discharge Planners’ Core Challenges

Once they have secured an avenue to develop relationships, PAC providers should offer resources and initiatives that, while benefiting the PAC provider, also support major case management team challenges. Four effective solutions that PAC providers and case management teams have found to address mutual challenges are outlined below:

### Key Case Management Challenges and PAC Solutions

<table>
<thead>
<tr>
<th>Opportunities for PAC Impact on Discharge Planner Needs</th>
<th>PAC Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accepting patients immediately upon readiness for discharge</td>
<td>1 24/7 Centralized Admissions Contact</td>
</tr>
<tr>
<td>• Easing ability to contact PAC provider staff</td>
<td></td>
</tr>
<tr>
<td>• Simplifying process of verifying provider ability to accept patient</td>
<td>2 Capabilities Checklist</td>
</tr>
<tr>
<td>• Improving patient information transfer</td>
<td>3 Effective Transfer Forms</td>
</tr>
<tr>
<td>• Avoiding last-minute patient rejections</td>
<td></td>
</tr>
<tr>
<td>• Gathering information on patient’s background to inform hospital care plan</td>
<td>4 Care Plan Input for Readmitted Patients</td>
</tr>
</tbody>
</table>

The remainder of this section explores these four solutions in greater depth.
Discharge Planner Challenge: One of discharge planners’ most crucial needs is the ability to quickly reach PAC staff at any time, enabling an efficient admission whenever the patient is ready for discharge. Busy discharge planners often end up leaving messages regarding potential referrals and waiting to be called back, wasting time and delaying patient discharge. Furthermore, if discharge planners can only reach admissions staff during business hours, patients already set for discharge must wait until the next day or even after the weekend.

PAC Solution: PAC providers should offer case management teams a direct cell phone number for a centralized admissions contact who can be reached at any time. They generally also provide a back-up direct number for the Director of Nursing to guarantee 24/7 coverage. This allows the PAC provider to communicate with discharge planners more quickly and to accept admissions 24/7, increasing discharge efficiency as well as the number of potential referrals.

In return, the case management team may help the PAC provider address challenges arising from expanded hours of patient admission. For example, Hospital E added an on-call social worker on weekends. Additionally, Hospital G learned that a major barrier for a SNF partner was the SNF’s inability to bill pharmacy on weekends, and therefore Hospital G’s case management team worked to obtain all possible medications while the patient was still in the hospital.

Results: Following implementation, Hospital E has seen its average length of stay drop from 4.11 in 2011 to 3.90 in 2014, a 5% decrease.

Capabilities Checklist: When a patient has specialized needs that not every provider is equipped to handle, discharge planners must spend time contacting various providers to verify their capabilities, which is inconvenient for the discharge planners and makes placement difficult. Furthermore, if a patient escalates while in post-acute care, physicians who are unsure of the PAC provider’s capabilities are likely to instruct the patient to return to the ED.

PAC Solution: PAC providers can offer the case management team consolidated, regularly updated information on their capabilities. Once compiled with that of all other PAC partners, discharge planners can tell at a glance which PAC providers they can offer to a patient as options and can share the checklist with physicians.

Since discharge planners will direct patients to the PAC providers with the capabilities to meet their needs, ensuring that the case management team understands all the PAC providers’ capabilities can significantly boost referrals for those capabilities.
PAC providers should be sure to communicate with their referrer partners to understand which capabilities are of most interest to the hospital. Hospital G brings a questionnaire on processes and capabilities of interest to meetings with SNF partners every month and asks them to update every question. Hospital G then inputs the information into an electronic log, which the case management team can quickly access when determining which SNFs are options for a patient.

Sample Questions About Capabilities, Hospital G

- How do you handle a patient on high-flow oxygen?
- Can you get someone to wound care? Dialysis?

### 3 Effective Transfer Forms

**Solution in Brief:** A universal transfer form created with both hospital and PAC input

**Discharge Planner Challenge:** Forms conveying incomplete or difficult-to-find information increase the risk of dangerous or inefficient transfers. Without the right information, PAC providers may reject a referred patient at the last minute, delaying discharge significantly. Alternatively, they may need to call the case management department back repeatedly for additional information once the patient has been admitted, taking up discharge planners’ and clinicians’ time.

**PAC Solution:** PAC providers and case management staff can communicate about needed information that is not currently included in transfer forms and begin to include that information. For example, at Hospital D, SNF clinical liaisons frequently asked the case management staff for 24 hours rather than two hours of vital signs and for normal as well as abnormal labs. So Hospital D now includes this information with the transfer information packet faxed to SNFs. Similarly, Hospital E created a custom form encompassing all the information it needed from SNFs, and asked its SNF partners to use this form when sending patients to Hospital E.

Once a mutually acceptable form has been created, directors of case management should ensure that ED physicians and case management staff understand where to find information on the form. Hospital C’s staff frequently reported that they did not receive all needed information for patients admitted from SNFs. So once the director of case management had created a form with all needed information with partner SNFs, she worked with hospital staff to explain that all information was now included in this form and educate them on where to find it.

### 4 Care Plan Input for Readmitted Patients

**Solution in Brief:** Approach case management staff with key information informing the care plan for readmitted patients

**Discharge Planner Challenge:** Discharge planners lack access to a patient’s full history, especially psychosocial information. They may therefore be unaware of critical patient information that could reveal barriers to a safe discharge which need to be addressed in the patient’s care plan.

**PAC Solution:** PAC providers can offer key information regarding causes of readmissions that the case management team would otherwise never know. PAC staff directly involved with a patient’s care, such as nurses, should therefore proactively contact the case management team when the patient is readmitted to discuss their perspective on factors causing readmission, which can then be addressed in the patient’s care plan.
While conducting joint root-cause analysis of readmissions after the fact is common at many hospitals, involving PAC providers in a readmitted patient’s care planning helps to address potential issues in the moment, rather than at a future date.

The director of case management at Hospital E learned the importance of PAC providers’ information firsthand. One patient with lung cancer and COPD had cycled through the hospital three times from a SNF. When the case management team brought a nurse from the SNF into a readmissions huddle, the nurse explained that the patient’s mother was sneaking her cigarettes and food that triggered her diseases. Because of the SNF’s information, the case management team was able to intervene with the patient’s mother, who stopped her actions with education and pressure from both the hospital and SNF. This ended the cycle of readmissions.

“This experience made the case management team realize how many factors unknown to them might cause a patient’s readmission and how important it was to involve PAC providers in care planning. It also improved relations between the case management team and PAC providers, as they gained a better understanding of the challenges PAC providers face.

The team now contacts the SNF or HHA to join a readmissions huddle for all readmitted patients. The team asks for a PAC representative to come to the hospital in person, or if the PAC provider is located far away, to join a teleconference discussion.

Results: Following implementation of this and other subsequent collaborative initiatives with post-acute partners, Hospital E saw a 24% decrease in its readmission rates.
V. Conclusions

Discharge planner relationship development should be viewed as a cornerstone of hospital outreach strategy and of quality improvement efforts.

Relationships with discharge planners offer a host of benefits for post-acute providers beyond direct referral generation. Because the case management department can have such strong influence on referrals, PAC providers commonly view directly attracting referrals as the sole purpose of developing case management relationships. However, discharge planners will almost certainly not direct patients towards one provider over another unless a formal affiliation is involved. Furthermore, such an approach neglects the many actual benefits that can accrue from collaboration focused on addressing mutual goals—including indirectly attracting referrals.

For PAC providers who instead adopt the approach of viewing discharge planners as partners in ensuring the highest-quality care and best experience for patients, relationship development can be easy and fruitful. Case management departments are willing and waiting to collaborate with PAC partners, but PAC providers must offer value back in return.
Methodology

Advisory Board researchers conducted a series of interviews with members of hospital case management teams regarding their roles and relationships with post-acute providers. The Post-Acute Care Collaborative would like to express its deep gratitude to the individuals and organizations that contributed to this research.

Research Contributors

<table>
<thead>
<tr>
<th>Institution</th>
<th>Institution Characteristics</th>
<th>Contact(s)</th>
</tr>
</thead>
</table>
| Hospital A  | • 250-bed, not-for-profit hospital  
               • Member of a 12-hospital health system located in the Midwest | Director of Case Management |
| Managed Care Plan B | • Managed care plan  
                        • Affiliated with 350-bed, not-for-profit hospital located in the West | Director of Case Management, Managed Care |
| Hospital C  | • 200-bed, not-for-profit hospital  
               • Member of a four-hospital health system located in the South, including flagship AMC | Director of Case Management |
| Hospital D  | • 200-bed, not-for-profit hospital  
               • Member of a seven-hospital health system located in the South, including flagship AMC | Director of Case Management |
| Hospital E  | • 250-bed, not-for-profit hospital  
               • Member of a three-hospital system located in the Midwest | Director of Case Management, Clinical Documentation, and Pre-Admission Nurses |
| Hospital F  | • 300-bed, not-for-profit hospital  
               • Standalone hospital located in the Northeast | Managers, Department of Care Progression |
| Hospital G  | • 450-bed, not-for-profit hospital  
               • Standalone hospital located in the South | Supervisor of Case Management |