

ADDRESSING THE LIMITS OF HOSPITAL-BASED CASE MANAGEMENT

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As the business of healthcare continues to become more complex and information-sensitive, hospital based case managers must align their roles with the organization's business strategies and market goals. In this environment, the case manager will be expected to establish strategic partnerships with the organization's stakeholders and independently initiate strategies that achieve the seemingly contradictory goals of cost reduction and value enhancement. How can this be done?

THE CASE MANAGER'S ROLE

Reports from the front lines of hospital based case management are coming in. How do I juggle multiple tasks? How does my role differ from the utilization review nurse? Do we really need a social worker? How can I engage the doctor? How do I demonstrate value to the organization? Does what I do make a difference?

To be sure, the hospital case management landscape is far from uniform. Models vary with the size and status of the organization, the prescribed purpose of the program, and the anticipated goals established during the development process. Still, at the top of the model pyramid, is the case management program which combines utilization review and discharge planning; activities generally viewed as inveterate obligations the hospital must perform either through contractual, regulatory or accrediting requirements.

Yet, precisely because the hospital has special obligations, its failure to effectively use the case manager WELL is special cause for concern. If we look at how case managers actually do perform their jobs, as opposed to how they could perform, then the case managers complaints reveal as many weakness as the hospital's expectations.

THE CLASSICAL MODEL OF HOSPITAL CASE MANAGEMENT

The classical model of case management found in most acute care hospitals evolved from the consolidation of discharge planning and utilization review departments. Typically, hospital case managers (HCM) working within this model, are overwhelmed with the tasks associated with perfunctory Utilization review and Discharge planning activities. Among them are the ritualistic chart reviews to provide information to the payer and to determine level of care. This information is often manually captured on a unit and then conveyed to a third party representative either telephonically, electronically, or collaboratively on site.

Case managers complaints about the hours wasted “on hold” with a payer, are legendary and on-site reviewers are a rarity as insurers attempt to rein in costs. Case finding to target patients for discharge and social work referrals is often an inelegant process highly dependent upon the case manager’s presence on a unit, relationship with the nurses or other care givers, and level of knowledge about a patient’s clinical or financial status. This component of the typical HCM role puts them in direct conflict with the hospital social workers whom have spent the last fifteen years preserving their hospital based jobs as administrators, in a moment of myopic whimsy, lay off social workers to reduce indirect service expenses. However, an informal survey by the author, of hospitals where case management programs were created by combining UR and D/C, indicate that overlapping, often redundant activities between the social workers and the case managers often result in avoidable delays, communication obstacles and turf tension between the disciplines. It’s not surprising that under these conditions, HCM express frustration and dejection supported by reports of burnout and frequent turnover.

The classical model also encourages little, if any support from members of the medical staff or investment by the executive team. From the physician’s perspective, the HCM role in this model is either viewed as another intrusion to control practice; or another name for the ubiquitous presence of someone “trying to kick my patients out of the hospital;” or even more sardonic, “someone taking up space at the nursing station reviewing charts.” Case managers, assigned to units in this typical model are often not expected to consort with the physicians, or are too busy performing tasks to make personal contact with the physician, or may not be available when the physician makes rounds. Some may be so intimidated by the physician, an assumption supported by the organizational culture, that they seek less personally threatening avenues to get information either through contacts with the nursing staff or burrowing their noses in the charts.

From the administration’s perspective, the case managers are simply performing perfunctory activities that need to be done to appease the payer and the regulator and to keep the length of stay to within acceptable parameters. Years of operational conditioning inhibit any thoughts of innovation when it comes to discharge planning activities and contractual obligations, often boilerplate language endorsed by the financial officer without any input from the case management staff, is generally the only source of information available to the executive staff regarding utilization management. And today’s administrators, worrying about meeting margins, working within a operating budget that gets leaner each year, and seeking new avenues of revenue to compensate for the diminished income from managed care contracts and the Balanced Budget Act, have little time to ponder the opportunities that case management can offer to the bottom line.

THE EFFECT OF CORPORATE CULTURE

Hospitals have always had a culture. With the proliferation of integrated delivery systems and hospital chains, it is not uncommon to speak of a corporate culture dominating the operating environment. These cultures influence the working conditions – the ways in which, say, the paternalism of IBM differs from the youthful entrepreneurship of Microsoft. Cultures come in weak and strong forms and hospital cultures have proven to be among the most durable. It is often this entrenched culture, dominated by sexist and paternalistic attitudes toward nursing and compounded by the unique parallel governance structure of hospitals, that separate members of the medical staff from the case

management staff. Other cultural barriers include the reluctance to aggressively market case management which perpetuates the perception that a utilization reviewer by any

other name is “still trying to get my patients out of the hospital;” accountability avoidance by using case managers as collateral enablers to expedite process and system blockages that add cost and risk to the patients, the payers, the physicians and the hospital; and finally, the inability and often the reluctance, to break down communication barriers and forge new partnerships with the physicians through daily rounds, discussions about treatment goals, expected outcomes and transition targets, and searching for rationale about practice decisions. However, the current economic environment has given birth to an incredible incentive for alliances.

New Opportunities for Partnering with Physicians

Because physicians act, after all, as small businessmen, they will seek to maximize income, reduce risk, and outperform competitors to maintain a target income level. They also have a “mental rheostat” that tunes in to the availability of resources in their communities. It is axiomatic in a fee-for-service environment, that contrary to classical economic theory, supply generates demand. And as Fee-For-Service is the reimbursement mechanism under which most physicians operate (in conflicting contrast to PPS for the hospitals), it is not surprising that there is little motivation to change practice behavior.

On the other hand, as physicians try to navigate the turbulent waters of managed care, cope with changing reimbursement methods and suffocating paperwork, and as patients become savvy customers armed with options gleaned from the Internet, they have become more receptive to advice and information that can protect them against the scrutiny of the external reviewers and shelter them against the unrealistic expectations of patients, families and payers. The introduction of objective clinical and financial performance profiles by hospitals and payers to use in credentialing decisions is further incentive for the physician to learn the rules of survival. Merging the physician’s professional autonomy and clinical expertise with a commitment to the hospital’s overall goals is a critical challenge that can be best met through a clinical resource management (CRM) approach to hospital case management.

The CRM Approach

In a traditional hospital case management model then, the limits of the case manager’s role is foregone. Neither the medical staff nor the administrative staff perceives or envisions anything more from the case management program than quickly moving the patients through the hospital continuum consistent with payer preferences and regulatory standards. Not surprisingly, under this perception there is little chance to attract the attention of the decision-makers or engage the medical staff.

Clinical resource management (CRM) is a “radical shift and fundamental rethinking” of the traditional hospital case management model. It is a basic challenge to the accepted wisdom of the role of the HCM. The dominant orthodoxy neither requires nor even encourages the case manager to think of the physician as the hospital’s key customer. To the contrary, the formal distinction between the physician as autonomous provider and the patient as passive recipient is seen as self-evidently correct. By implication, the case manager must stay focused on the patient who is most needy of advocacy. However, we fail to recognize that one, the professional nurse is, by profession standards and by license, the patient’s primary advocate and what would be the benefit of creating a hospital-based model of case management that places the case manager in competition

with that role; and secondly, that inpatient beds will not be filled without benefit of the physician's influence. All evidence supports this fact. Though managed care has

narrowed options for its members; the physician is still the dominant player in the decision about where the patient will go.

This is a hard notion to sell to patient-focused leaders and it does require a shift in orientation. But this change can translate into value to the organization and to the patient and still improve the life of the case manager. To gauge the full magnitude of the potential benefit of this shift, consider that 60% to 80% of clinical costs are a result of medical interventions and that, depending upon what article you read, upwards of 15 – 20% of those interventions are either inconsistent with research evidence, do not contribute to the desired outcome, or are prescribed because the patient expects it. Every case manager can relate stories about physician practice styles. I've had engagements at hospitals where the case manager can predict the number of consultants that will be brought in on a case based solely on the name of the attending physician – rather than what the patient needs! And how many readers can confirm the typical physician response “that's the way I always do it” to the query about the order for a series of radiographic tests when one test is considered definitive. It's pretty clear that in this scenario, the pen, quite literally, is mightier than the sword.

Yet it is precisely those habitual, non-contributory interventions that add unnecessary costs and introduce potential risk to each of the stakeholders. Shifting focus to the physician as the hospital's key customer requires a shift in the structural and operational strategies and expected outcomes of a hospital based case management program yet it does not compromise the core principles of a professional case manager. No longer is the purpose to simply provide discharge planning as in social work or to ensure appropriateness of care as in utilization review. The purpose of a clinical resource management model is clearly to improve the bottom line – both clinically and financially – and in doing so, ensure continuance of the hospital's mission to its community. Under this plausible approach, the goals may include reduce cost per case, reduce avoidable, non acute days and payer denials, minimize complications, create a hassle-free hospital visit for the physician, provide documentation coaching to promote accurate reimbursement and truthful severity of illness assignment, streamline delivery of care processes, offer a real time partnership to the physician, encourage patient participation in treatment decision making, and engage the physician as an enthusiastic proponent of case management. Each goal serves to support the purpose and the people served. Reducing payer denials means greater revenue for the organization which translates into more resources for the staff, the patients, the community. Improving documentation to garner accurate reimbursement translates into full reimbursement for the organization and the physician. With the ability to maintain his income, the physician is less apt to prescribe interventions that are non-contributory which means that the patient will not be exposed to unnecessary risk associated with every hospital stay.

The tools are already in hand and have been utilized to make transformative change to traditional case management programs across the country. While experience has proven that key tenets govern several strategic initiatives for the structural and operational redesign, there are as many variations on how these goals are accomplished as there are hospitals. It is not the purpose of this article to ferret out those strategies and tools that work but rather to spark further dialogue about the potential benefit of plotting a new course. As part of the design process however, it would be prudent to recognize that if a case manager is burdened performing tasks that either could be done by the primary

process owner or by less costly personnel, they will lose sight of their crucial purpose and the program will deconstruct. Each of the goals expressed previously have bottom line value that can be measured in terms of dollars and positive outcomes. Once a case management program measurably demonstrates cost savings, glowing patient endorsements, expense reductions, better clinical outcomes, and physician buy-in, the executive team will respond accordingly and the case manager's fortune will get the boost it deserves.