<u>Designing a Hospital Case Management Program</u>

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Designing a hospital case management (CM) program for all those bottom-line obsessed, information-craving executives presents an interesting challenge and a wonderful opportunity for administrators of care management programs and case managers to demonstrate the quantitative value of their hospital case management program. There are two perspectives of value that can be used to assess hospital case management program. C*ustomer value* is the intangible perception of what customers want to happen in a specific situation based on the service offered. On the other hand, *program value*, is tangible proof that the investment of resources to provide a specific service is worthy of continued support and future expansion. Determining the first is a must to compete successfully in today's health care environment. Without *customer value*, loyalty to the organization is compromised, as are market share and profitability. However, *program value* however, is critical to secure future investment to grow, expand, and reach beyond the boundaries of the acute care setting. This article suggests several dynamics at play in determining successes, future investment, and the evolutionary growth of hospital case management.

An organization's choice to invest in a case management program is generally governed by two defining characteristics: (1) the primary objective of the case management program and (2) the degree to which case management operations are linked to the hospital's strategic direction. The latter refers to the alignment of the program's goals, its practical day-today application, and its outcomes, with the hospital's ability to achieve its business goals. A well –structured and operationally congruent case management program brings new opportunities to build or strengthen alliances and sharpen operational capabilities, which are important goals for any business enterprise. Viewed from this perspective, hospital case management is a valuable asset to the organization. Then why do some programs languish with high attrition and low morale while others generate excitement and confidence? Why are some programs more successful and optimistic about the future, while others are seen as perfunctory piranhas with neither the finesse nor the agility to perform successfully in a high-risk, fast-paced environment?

Issue #1: How to Mediate Stakeholder Expectations

Hospitals have, at best, a mixed record of collaborative planning. The image of parallel silos can best describe the typical bureaucratic structure that creates false boundaries among and between hospital activities. For example, the 'idea' of case management may emanate from the Chief Financial Officer (CFO) and may even have the blessing of the Chief Executive Officer (CEO). However, for reasons as varied as turf protection or operational expediency, specific direction is not always shared, discussed, or negotiated. Although there may be general support for a case management program among the executive team members, a clear, universal understanding of the purpose, intent or goals of the program is not always evident. Consequently, members of the executive staff have different expectations that may run counter or even conflict with their peers. Mixed messages are relayed through the hierarchy often leaving subordinate departments poorly informed about the program and its intent.

Interventions for Issue #1

Concept congruency refers to the universal understanding and acceptance of what a case management program is intended to achieve on behalf of the organization. If a hospital has a case management program, it is generally up to case management leadership to take steps to ensure that each member of the executive team shares a common understanding of the program and to begin the process of *value-improvement*: rethinking the program from a bottom-line, customer-centric perspective. As a first step, the leadership group must clearly articulate a vision of the future, and explore the full range of benefits that can be derived from a transition to a *value-model*: one that reflects the expectations of your key customers. The vision must represent the interest of the program's customers and values that are important to the organization. The group must ensure *concept congruency* among themselves before they can expect the rest of the case management team or the executive staff to buy into the vision as well.

Lack of vision is often the single most significant impediment to the design of a fully successful case management program. Hospital executives and case management leaders have ample opportunity to develop programs and accompanying processes that will benefit the organization's stakeholders: the individuals who will be affected, directly or indirectly, by the operations and outcomes of the case management program. However, bold initiatives are rarely encountered. And although accrediting requirements, regulatory oversight, physician resistance, and an imbalanced reimbursement system are often cited as reasons for caution, the more innovative case

manager leader could view them as a call to action. To overcome this bias toward the status quo, a collaborative action by the case management team with mission-related team members is warranted. Pressure from many sources, including some physician champions, backed with a bold vision and substantial information, can help responsible hospital leaders migrate from inertia to innovation. But first, the players must know the key issues involved.

Another intervention is a visioning exercise facilitated by an objective third party. This is a highly worthwhile endeavor because it offers team members who have been living and breathing the current version of case management an opportunity to see beyond the boundaries of their own reality. Visionary 'due diligence' is performed by interviewing associates to confirm congruence with the organization's strategic business plan and to capture the collective knowledge inherent in the organization. A practical vision of the future becomes a living, breathing template for everything that follows. It is *what* the program is all about, and leaves plenty of room to experiment with the *how*.

With a solid vision of what the future of case management should look like, the purpose and goals of the program then should be articulated to reflect the vision realistically. The purpose should be expressed in terms of practical and meaningful ideals and explain "what" the case management program is all about. Although a puirp0ose might include words such as "cost-effective care," a goal should be more specific: 10% reduction in avoidable days attributable to discharge delays within 6 months. One caveat: be very careful about generating goals that go beyond the scope of the case management program. A carefully chosen goal, expressed with objective criteria, is value added. That is, the outcome is a direct result of the work of the case manager, and can then be utilized to track whether the program is having the anticipated impact. The effectiveness of a hospital case management program begins with the team's understanding of the strategies value of a hospital CM program and its acceptance of the intent and the goals. People engage most, and their talents flourish best, when job responsibilities, business objectives, and evaluation criteria are clearly understood.

Issue 2: Consideration of the External and Internal Environment

C*ontent Congruency* refers to the alignment between the vision, purpose, and goals of the CM program and the environment in which it is practiced. The environment dictates the best approach for the design of structural and operational parameters of the program. The structural and operational organization of the program must be designed so that the team can collectively fulfill

the purpose and achieve the goals of the program. Too often, the formal organization of the case management program is a bureaucrat's conception of how the program objectives should be achieved. Consequently, CM is reduced to task specialization that often results in the simplification of the job so that it becomes repetitive, routine, and unchallenging.

Interventions for Issue 2.

Revisit the *structural model* of your program. How the program is positioned on the table of organization is an important variable on how it is perceived. How is it *vertically aligned?* Is the vertical alignment - the link between the hospital executive and the program leader - congruent with the vision, purpose, and goals of the program? For example, one purpose of many hospital case management programs is to influence physician practice behaviors. There are several reasons for this. First, more than 60% of admissions to the hospital are a result of physician choice, so the physician is arguable, the hospital's key customer. Second, physician ordering habits are responsible for 60% to 80% of clinical costs. Third, practice variation among similar patients gives rise to dramatic statistics about the percentage of care that is unnecessary and inappropriate. Finally, physician-directed interventions are directly or indirectly responsible for clinical and financial outcomes. If you want to improve clinical and financial outcomes, the driving principle - part of a vision, if you will - is that you must actively engage the physician and motivate change in practice decisions. If your program includes influencing physician practice behaviors as a major purpose, then positioning the case management program under a vice president of medical affairs or chief financial officer may send the most meaningful message to the medical staff.

Horizontal alignment, the flow of information across the organization, improves decision-making among related activities, increase coordination of functions, and promotes lateral relationships. In addition, it reinforces and broadens performance excellence and facilitates efficient use of resources. In the absence of tight lateral relationships, case managers find themselves entangled in power conflicts, bruised by rivalry, and thwarted by bottlenecks in decision-making. Aligning similar, mission-related activities under a single administrator usually overcomes these obstacles, increases productivity and efficiency, improves the way team members interact and goes a long way to develop healthy inter-group relationships.

C*ontent congruency* also should be considered when discussion how the best deploy case management resources. Typically, case managers are assigned to geographic areas. However,

using the example above, if the vision/purpose is to influence physician practice, careful consideration and exploration of the pros and cons must be given to the advantages of assigning a case manager to groups of physicians.

Issue 3: Effective Use of Resources

The work of the case manager varies considerably from organization to organization. The challenge is to design the job with enough flexibility to meet unsteady circumstances, brought on in the workplace by changes in the internal or external environment. All too often, despite much research on what constitutes a productive, rewarding work environment, examples of counterproductive job responsibilities among case mangers can be found all too easily. It would appear that case management program directors have ignored the psychological and social aspects of work to the detriment of the organization, the case management staff, and the stakeholders served by the hospital. Opportunities (and the benefits flowing from these opportunities), and the development of problem solving skills among case managers are being squandered.

Anecdotal information elicited from case mangers often supports the contention that high levels of task rationalization are associated with high levels of boredom and burden, which in turn are associated with job dissatisfaction, counterproductive worker behavior, and poor outcomes. The problem of process congruency - the fit between the fundamental processes that characterize the program and the desired outcomes - is one of the dynamics that the organizations forces upon many case managers. Case manager activities are not always congruent with program goals; and the case manager's perceptions of the program are not always congruent with the tasks she must complete. One sure sign of a healthy, productive, and successful case management program is agreement between the program's purpose and goals and the daily activities of the team members.

Interventions for Issue 3

One method of evaluating work activities is to assess the level of value the activity brings to achieving case management goals. For instance, using the example of influencing physician behavior, any strategy, activity, and resource that supports or promotes a strong physician-case manager partnership should be considered and given priority. Put another way, if you can identify a cause-and-effect relationship between the activity and the intended objective, then it is a value-added task. However, if there is no direct cause-and-effect relationship, then the activities may best be delegated to someone other than the case manager.

Utilization review (UR) is a classic case-in-point. Utilization review, as practiced in most hospitals, is a contractual obligation between the hospital and the payer, entered into by the CFO with little regard or knowledge of what impact the boilerplate language concerning utilization review will have on case management operations. Because the hospital, not the physician, is placed at risk for appropriate admissions, contractual UR requires that the hospital demonstrate adequate justification for an acute care admission. Justification is derived from criteria used by the payer - and the provider - to determine admission and continued stay appropriateness. InterQual and Milliman and Robertson are among the most popular vendors of acute care criteria. Typically, the case manager searches the medical record for evidence that the criteria is met, and enters the information culled from the record into a computer system or verbally transfers it to the payer representative. If the primary purpose of hospital case management is to facilitate the delivery of appropriate care in a cost-effective environment, it can be argued that conducting UR is hardly an effective method, or an efficient use of scarce professional resources, to ensure "cost effectiveness." Demonstrating a cause-and-effect relationship between reviewing a medical chart and reciting or rewriting the findings to achieve "cost effectiveness" appears, on the surface, to be a tenuous connection, unless the purpose of the case management program is to conduct utilization review. If so, then one has to ask, why have a case management program in the first place.

The Value Challenge: Case Managing for Outcomes

If your CM program isn't supercharged for value, the reasons may rest unresolved and likely to plague any future improvement initiatives. Take a closer look, and you may find the shortcomings were caused by some combination of the dynamics just described.

Achieving success demands shifts in thinking about CM, in how your CM program is organized, in action, and most important, in outcomes. Task completion is not an outcome. At the core of outcomes is access to data. Though outcome management is still in its infancy, case managers must embrace the information and technology available from multiple sources and acknowledge that case managing for outcomes offers a strategic advantage.

Hospitals are replete with data assets but much of the data remain underused, at best. Most of the uncultivated value of these data lies in the wealth of descriptive and predictive information that skillful manipulations and analysis can reveal. The growing sophistication of integrated

databases for real-time access and instant analysis is fast becoming an essential tool for hospital case managers. In many organizations, a decision support team, independent of the hospital information technology (IT) function any specific service area, is equipped with up-to-date analytical horsepower to work with the case management program. The team is often a staff unto itself that serves many internal customers.

Most hospital executives have a clear sense that significant improvements are still possible in their complex organizations. Even in the best-managed hospitals, there is a continuing search to find opportunities in cost, quality, and revenue. Similarly, many case management programs search for opportunities to measure value. However, many fail to measure the right things and miss a strategic opportunity to exploit the synergy between the organization's goals and the case management program.

For example, one client showed me data on how the case managers spent their time. Using four-color printouts, the director proudly demonstrated how she compiled 'activity reports,' which each case manager was required to complete at the end of each workday, categorizing their time into specific works areas based on the tasks they accomplished. Probing a little more, she acknowledged that the reports were stored on a shelf in her office and we used annually to advocate for additional full-time employee - which, incidentally, she never received.

To capture the attention of the decision-makers, the CM program must dovetail its outcomes with those of the hospitals. Using a variety of outcome indicators to examine and measure processes and outcomes, CM can provide objective f feedback to delivery-of-care providers to support thei4 willingness to change or improve processes that affect the patient's ability to navigate the acute care continuum. Comparative analyses trended over time help prioritize performance improvement in practice decisions and can be used to objectively quantify variations in treating similar patients. On every level, data mining to generate outcomes will result in more insightful information and increased understanding of the impact of case management on processes and practices.

The most effective information is generally physician specific and severity adjusted. As an example, it's been my experie3nce that physicians will pay more attention to the hospital's postoperative infection rate if it is presented in a comparative format with the physician's infection rate compared to those of his peers or to an internal benchmarks. Similarly, reports listing aggregate avoidable days each month have little impact on process of care or practice behaviors. However, avoidable days identified by attending physicians and the attributable service area will generate heated discussions and subsequent action.

The Value Challenge: Return on Investment

More than any other hospital service program, case management must find a way to prove its value. The final step of the value-challenge is use of objective outcomes to calculate return on investment (ROI). Return on investment is the total quantitative savings (or return) in dollars generated by an improvement, divided by the cost of that improvement. Calculating ROI may involve measuring an increase in revenue, a decrease in expenses, or an avoidance of an expense. This is typically expressed as either a ratio (9:1) or a percentage (120%). This article is not intended to be a text on how to calculate ROI, but simply to point out that, faced with ever-tighter reimbursement and escalating competition, hospital executives are showing increased interest in using comparative data and ROI analysis to assess value of a hospital program. As Rieve (1997)* states, "case managers are in a pivotal position to help healthcare organizations improve and demonstrate better outcomes and, at the same time, prove their own value by participating in developing case management outcomes and benchmarks." With a solid foundation and an accurate roadmap, hospital case managers can smoothly and safely guide patients and physicians down the appropriate path and secure value for ht entire community.

* Rieve JA. (1997). Benchmarking and using outcomes data. Case Manager, 8(4),55-61.