DON'T SQUANDER CASE MANAGEMENT RESOURCES

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ISSUE

Economic issues continue to take center stage in the healthcare arena as the sector's share of the gross domestic product has risen. And while physicians represent less than one half of 1% of the population, they determine, through the practice decisions they make about the care of their patients, how nearly 15% of the nation's gross domestic product will be spent. This immutable fact helped our hospital redesign its case management program and may serve as a guide to help others.

The key concepts of case management have been set forth by many writers and were used by the leadership team at our 92-bed community hospital to design a case management program. We created improvement teams, reviewed the literature, contacted colleagues in other hospitals and eventually implemented what we thought would be a case management program to take us into the future as we expanded into the community. We soon realized that we missed a real opportunity to leverage our investment in case management resources

For starters, the vision and purpose we initially articulated needed strengthening. Sure, we wanted cost effective quality care but translating that desire into the sharp reality of the real-life hospital world took a wrong turn. When we completed our six-month self-study evaluation, we recognized that the perfunctory tasks associated with discharge planning and utilization review were taking our high priced, advanced degreed case managers away from the physicians' side where they could best influence practice patterns and behaviors. We found that they were working parallel to, in conflict with, or, at times, in lieu of a social worker. Case managers reported spending too much time fielding phone calls to and from payers, serving as the 'chart police' to make sure that documentation written by the physician justified the admission or continued stay of a patient, or filling out the countless number of forms demanded by outside agencies.

It's no secret that physicians drive upwards of 80% of clinical costs, but our program did not support the hospital's most needy case management customer: the physician. Although it was not our intent, the model of case management we designed turned out to be something revolving *around* the physician rather than *with* the physician.

Although it may go against the grain of many conventional pundits, the concept of a customer-driven case management program targeted at the physicians appeared to us to be a powerful strategy to reduce costs and improve care. Physicians are the first to admit that they would rather manage *care* than manage the *business of care* and so we designed our model to partner the case manager with groups of physicians. We shared comparative performance profiles with our medical staff, but we neglected to severity adjust the data and compromised the credibility of the information. Although we knew that practice variations and non-contributory medical interventions add unnecessary clinical and financial risk, we limited the opportunities for the case manager to coach the physician on the very issues that directly impact outcomes of care and may indirectly impact the physician's economic future. At the six-month mark, we acknowledged that with the case managers spending so much time completing tasks, the program neither supported nor encouraged cost containment or quality care.

INTERVENTION

We found the key to unlock the potential of our program during our attendance at the Case Management Society of American (CMSA) conference in Tampa. There, we learned of an outcome model of hospital case management that identified the missing link and allowed us to capitalize on our intuitive decision to assign the case managers to groups of physicians. Taking our cue from the presentation by PHOENIX Medical Management, Inc., we realized that we neglected to consider the issue of operational congruence. Congruence refers to the fit between the case management model and the social and operational context of the hospital environment. In other words, to achieve the scope of clinical and economic outcomes we envisioned, we had to modify our program processes to complement the realities of the hospital culture, its operating systems, and the push and pull of expectations among the physicians, the executive team, and our associates in order departments.

Perhaps because case management is sometimes seen as synonymous with managed care, it if often perceived as an adversarial, hospital initiated challenge to the physician's autonomy and intrusion into the patient/physician relationship. That is the reality faced by many case management programs. Therefore, to be successful, we had to acknowledge this potential obstacle and devise strategies to overcome it. Fortunately for us, the decision to partner the case managers with groups of physicians was an elegant strategy to counteract those perceptions if indeed they were ever present in our facility. We simply pushed the envelope and challenged the case managers to use their relationship with the physicians to create value-added, real-time partnerships.

WIIFM STRATEGIES

With the help of our professional advisors, we recognized that to engage the physician in a partnership, we had to answer the question "What's in it for me?" (WIIFM) from the physician's viewpoint. For example, using that perspective, we knew through physician focus groups that the one asset almost as important to physicians as achieving good outcomes is conserving time. Over and over we heard physicians lament about time lost due to hospital inefficiencies. We determined early that if the case management program could measurably reduce the time the physician spent on redundant activities, we would gain credibility. Similarly, we calculated that if the number of intrusive phone calls to the physician from medical records personnel could be dramatically reduced due to the case mangers' real-time assistance with medical documentation, we would be offering a value-added services. And finally, our hospital, like hospitals across the country, is witnessing the partial collapse of the physician-patient relationship as patients and families have become savvy customers often armed with more current information about their illness than the physician has. Moreover, increased regulatory and payer oversight has placed additional burdens on the physicians forcing them to work harder and faster. In this stressful environment, it is unrealistic to expect physicians to keep pace with the business demands of their hospital practice. And despite their best efforts to stay medically current, it is likewise unlikely that a physician will give up precious time to consider new practice approaches, better documentation, or involve themselves in hospital improvement projects. Following an intensive 5-day educational program and armed with this reality, the case managers began the process to reorient themselves to the issues related to the business of managing care. They started reading more healthcare periodicals; the cut out articles about new research that they thought their

'partner' would value; and they worked with medical record coders to gain better understanding of documentation compliance issues, and became savvy about applying that information to Medicare Part B billing. Ultimately, they began to show the physicians actual outcome data that unabashedly demonstrated the case managers' impact on streamlining delivery of care processes.

Once we realized the obstacles we unwittingly placed between the case manager and the physician, and with the ongoing help of our team of expert advisors, we restructured and reorganized our case management program over a 6 month period. We positioned the social workers as "consultants'" to the case managers and recruited an analyst to compile data and conduct contractual utilization reviews. We now provide a tangible incentive to the medical staff in the form of a credible, competent, and reliable business partner. With a new understand of customer relationship marketing and armed with essential resources, knowledge, and objective information of value to the physician, the case manager is now positioned to help the physician navigate the turbulent waters of the acute care environment. We are building on a solid relationship of trust and mutual respect and have already seen evidence of a greater willingness by the physician to consider acceptable practice alternatives. It is our contention, backed by initial supporting data, that the physician-case manager partnership combined with objective information about how the physicians' practice, will motivate improvement in practice performance. In so doing, our hospital will realize cost savings and better outcomes of care.