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Hospitalists and Case Managers

The Perfect Partnership

[QA1] **Marianne McHale Ramey, and Stefani Daniels**

Part of every hospital case manager's strategic advocacy is the promotion of a consistent partnership with the patient's primary clinical player. The presence of hospitalists, a new and growing specialty, offers the case manager an opportunity to advance that partnership. Instead of having to wait for a doctor whose practice is outside the hospital to review a test result or order a procedure, hospitalists can do the same thing faster—leading to greater efficiency, better care, and shorter stays for patients. Unlike private attendings who visit their hospitalized patients once a day for a few minutes, hospitalists spend all their time at the hospital. It's a perfect arrangement for a dynamic point-of-care partnership.

BACKGROUND

The hospitalist is a relatively new specialist to enter the healthcare provider arena. The term "hospitalist" was first coined by University of California, San Francisco, internists Robert M. Wachter and Lee Goldman in the pages of the *New England Journal of Medicine* in 1996 (Wachtner & Goldman, 1996). In the following year, a new medical society was formed, which subsequently became The Society of Hospital Medicine (SHM).* SHM defines a *hospitalist* as a "doctor whose primary professional focus is the general medical care of hospitalized patients" (SHM, 2004). It is a specialty whose focus is the site of care (the hospital) rather than a disease (e. g., oncology), an organ (cardiology), or an age group (pediatrics). Hospitalists coordinate and oversee the care of the hospitalized patient from the time they are admitted to the time they leave, and they can respond quickly to changes in the patient's status. According to the SHM, the majority of hospitalists, approximately 83%, are trained as internists, with another 5% being from subspecialties such as pulmonology and critical care medicine (SHM, 2004).

Hospitalist programs have grown exponentially and are predicted to continue in popularity. In the mid 1990s, there were approximately 800 hospitalists (Fig 1). By 2003, that number had grown to around 8,000. The growth is expected to continue, with an estimated 25,000 practicing hospitalists by 2010 (SHM, 2004). Hospitalists can be found in many of the nation's prestigious hospitals, including The Mayo Clinic, Cleveland Clinics, and the hospitals of the Universities of California, Chicago, Pennsylvania, and Michigan, to name a few.

The managed care industry and the Balanced Budget Act together contributed to the hospitalist movement, as hospitals merged or closed and emergency departments began feeling the stress of diminished bed capacity. In both cases, the quest for lower costs and lower lengths of stay was motivation to place a full-time "inpatient physician" in the hospital setting. In addition, the hospitalist movement may also stem from the way family physicians and

*The Society of Hospital Medicine was formerly known as the National Association of Inpatient Physicians (NAIP). For more information, visit SHM at www.hospitalmedicine.com.

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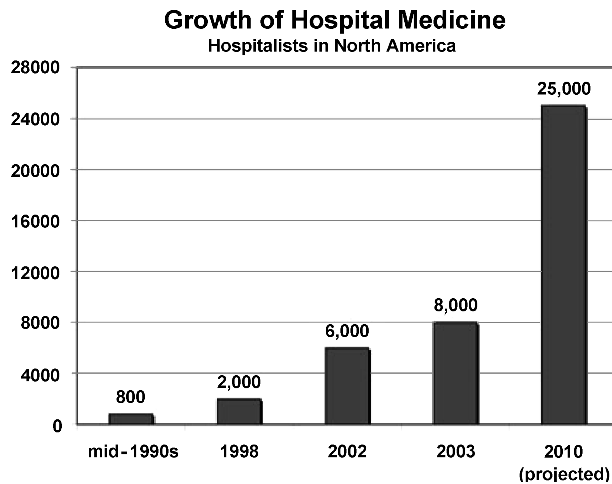

FIGURE 1
Growth of hospitalists in North America.
From Society of Hospital Medicine. Retrieved April 15, 2004, from http://www.naiponline.org

internists changed their practice in response to growing reimbursement pressures. Physicians, who were predominantly solo practitioners, moved into group practices to share responsibilities and expenses. They quickly realized that it was much more efficient to send one physician to the hospital each day to see all of the patients for the group. The other physicians stayed at the office, reducing the time spent in commuting and eliminating the prospect of starting morning office hours late. Most groups rotated the hospital duty. It made sense, and there was good communication between the physician at the hospital and the partners back at the office. With the doctors increasingly taking call for each other or rotating coverage, continuity of medical care was impacted. Eventually, practice reality led to the recognition that continuity can be improved with the presence of a dedicated inpatient physician. The model was formalized when physician entrepreneurs formed companies to provide hospitalists on a contractual basis.

Depending upon the hospitalist model being used and the type of hospital in which the program operates, the role of the hospitalist may vary. While all programs focus on the care of the hospitalized patient, many programs include responsibility for seeing patients in emergency departments and clinics, assuming the care of the indigent and uninsured who may not have a primary care physician (PCP) in the community. Many academic hospitalist programs include teaching and mentoring of interns and residents, and there are articles in the literature reporting that hospitalists have assumed greater roles in performance-improvement projects and the development and application of evidenced-based protocols.

In the decade since Dr. Wachter first coined the term, the hospitalist trend has taken off, and although there is relatively little defined in terms of licensure or training requirements, residency and fellowship programs have blossomed and the hospitalist role in the acute care setting has become pervasive in some areas of the country.

The trend appears to be growing. There is evidence in the literature that it costs less to care for patients managed by hospitalists, and attending physicians are less threatened by the concept and have acknowledged the value of the hospitalist's expertise and continuous availability (Manthous et al., 1996). The presence of the hospitalists and their intensivist counterparts (hospitalists who specialize in the care of critically ill patients) are quickly gaining acceptance among patients and families. It is safe to say that hospitalists are here to stay.

Many PCPs were at first skeptical, at best, and in some cases, openly angry about the use of hospitalists. Some saw the arrival of the hospitalist as an intrusion on the sacred "patient–physician" relationship and were worried about the potential for fragmentation in care. Others were concerned that the loss of inpatient revenue would erode their incomes and that they might lose their patients entirely. Some have been outright rebellious in accepting the hospitalist when forced to capitulate by some payers. In the early 1990s, the heavy-handed actions by several health maintenance organizations prompted some state legislatures to prevent managed-care organizations from "mandating" the use of hospitalist by their PCPs. However, as the acuity of patients has risen and more care is being provided in the PCP's office, many family practice physicians and internists have realized that they can no longer spend the time in the hospital and still maintain a profitable office practice. In addition, many business-savvy PCPs recognize that income from a higher volume of office visits is often greater than revenue generated from hospital visits. According to Dr. Wachter, "Patients are in the hospital today because they need a ton of care. Quite often the primary care physician cannot be there when critical decisions need to be made" (McCain, 2001). As the commodity of time becomes further compressed with the increasing demands being placed on physicians, most PCPs have grown to appreciate the value of the hospitalists and have accepted them as the fastest-growing specialty today.

The Perfect Partnership

As the trend is becoming the norm, it is a good time to consider the relationship between the case manager and the hospitalist. We have long held the position that the best place for a case manager is at the

physician's side. "Within the context of the customer-service provider relationship and given the growing emphasis on achieving measurable outcomes. …the physician is, arguably, the hospital case manager's most needy customer and should be the primary target of the case manager's day-to-day interactions" (Daniels & Ramey, 2005). The physician–case manager partnership is basic to any hospital case management program that is trying to promote more appropriate use of resources, reduce financial and clinical risk to its stakeholders, and improve the quality of outcomes.

But as every case manager knows, it is often easier said than done considering the huge variability in physicians' rounding patterns. Some arrive very early before surgical procedures begin. Others come at lunchtime when there is a break in their office hours. And still others come at 2:00 a.m. to avoid families and the case manager! With so many physicians and so few case managers, it is often difficult to bring the two together. However, when the case manager is partnered with the hospitalist or intensivist, the entire equation changes for the better.

Obstacles Become Opportunities

The advantage of the hospitalist–case manager partnership rests with the commonalities of goals. Since their arrival on the acute care scene, case managers have had to deal with the uneven playing field that exists between physician practice incentives and the hospitals' financial goals. Attending physicians have had little or no vested interest in whether or not the hospital gets reimbursed for its services. The physician gets paid for his services regardless of hospital inefficiencies and historically held little concern and at times outright contempt for the hospitals' financial concerns. On the other hand, the hospitalist and intensivist generally have different incentives. By and large, they are salaried employees of the hospital or a group of contractors with compensation packages that often include incentives for economic and clinical outcomes. Hospitalist contracts often include language that stipulates the application of evidence-based protocols and expectation of outcomes that meet key clinical and financial benchmarks. Although the traditional attending physician may feel that visiting a patient in the hospital is a necessity, albeit intrusive use of his valuable time, the hospitalist's full attention is on the hospitalized patient. The hospitalists' professional and economic incentive is to help the patient efficiently and effectively navigate through the acute care setting and transition back to the PCP in the community. Their presence supports concurrent consideration of resource management issues, better transition planning, and excellent documentation for both quality initiatives and hospital reimbursement.

Clearly, the goals of the hospitalist are closely aligned with the goals of the case manager:

- To facilitate the delivery of high-quality care through the application of evidence-based medical protocols;
- To promote cost-efficient care with practice interventions that are intended to support the patient's treatment plan;
- To eliminate the use of noncontributory, nonessential interventions;
- To access and share information that may impact hospital reimbursement;
- To provide services, treatment, and care to meet the patients' immediate acute care needs—nothing more and nothing less; and
- To move the patient to a lower, less risky, level of care when the patient no longer needs acute level of care.

With both groups sharing mutual goals, they can and must work as a team to achieve them. They must be in "lock-step" marching together toward their desired outcomes despite some of the obstacles that are bound to surface—especially regarding assignments and scheduling.

The Issue of Continuity

Depending upon the staffing model, the issue of medical continuity is more or less problematic. Some hospitalists work block schedules of 7 days and then have the next 7 days off. This schedule leaves plenty of room for the physician to pursue personal interests and is often a recruiting incentive. When there is a consistent hospitalist replacement for the next 7-day cycle, it generally doesn't present any gaps in continuity, but if not, it means that the case manager following that patient may encounter multiple hospitalists who have been assigned to those patients. Some hospitalists work only on weekdays while others rotate shifts, leaving the case manager trying to figure out which hospitalist is caring for his or her assigned patients and the hospitalist trying to figure out which case manager is following a particular patient. In some programs, the case manager is formally paired with the hospitalist and they share the same work days and the same days off. Hospitalist–case manager partnerships are further compromised in a rigid geographic case management assignment model. The hospitalist (and the patient) will encounter different case managers with each patient transfer or transition to a lower level of care. Continuity is a real issue for hospitalized patients.

The use of 10- and 12-hour nursing shifts, rotating hospitalists, and geographic case management assignments often means that the patient is the only consistent variable in the acute care continuum!

Staffing and assigning case managers to hospitalists usually depends upon the number of annual patient days that the hospitalist generates, the general rule being that one case manager, with adequate support staff, can successfully manage a caseload of patients representing up to 4,500–5,000 annual patient days. However, because there is no standard approach, and because of the wide variety of scopes of case management practice, the hospital case manager must be considered an essential element of the hospitalist program and positioned to maximize continuity, promote seamless handoff among hospitalists and case managers, and minimize communication gaps.

DEFINING THE PARTNERSHIP

Hospitalists are not simply internists without offices. The best of them are dedicated to managing the healthcare system on behalf of their hospitalized patient. They see themselves as a "team leader," mobilizing the expertise of the ancillary providers to ensure that the patient receives the best care in a timely manner. An article in the *American Journal of Medicine* surveyed hospitalists and asked them to rate the relative importance of specific aspects of hospital care, and then to rate the quality of their training related to these areas (Plauth, Pantilat, Wachter, & Fenton, 2001). Most discrepancies noted between clinical practice and residency training involved the following areas:

- System issues
- Utilization review
- Quality assurance
- Healthcare economics
- Medical administration
- Communication skills
- Coordination of care between settings
- Knowledge of home care and hospice
- Assessment of functional status
- Geriatrics
- End-of-life and palliative care

It is precisely because of these training gaps that the hospitalists look to the case managers to follow up on post–acute services, interact with the health plan, liaison with families, arrange follow-up appointments with the patient's PCP, and track data for improvement. With the case manager positioned as a partner to the hospitalist, a dynamic team with shared vision and goals is formed. The case managers' focus remains the same, but is now strategically aligned with that of the hospitalist physician, providing even further opportunities to rein in costs. The Case Management Society of America (CMSA) defines the scope of the case manager's practice as including assessment, planning, facilitating, and advocating on the patients' behalf (CMSA, 2002). All of these activities are perfectly aligned with those of the hospitalist.

The delivery of care in this (hospitalist) model should be very similar to a performance by an orchestra, with the hospitalist physician being the composer, the case manager being the director, and all the other varied and diverse healthcare team members playing their individual instruments. The hospitalist has written the music and the case manager makes sure that each member plays his or her part in time and in tune.

Imagine a hospitalist–case manager team that not only anticipates each other's needs but also the needs of their customers, the patients. They meet every morning for rounds along with the charge nurse on the unit. Then, later in the morning, they meet with the multidisciplinary team to map out the strategy for the day and the plan for the stay (Zander & Karen, 2003). The physician clearly articulates (and documents) the desired outcomes for the hospitalization and the clinical milestones that must be met for the patient to be transitioned to another level of care. All team members know their part and take responsibility for their contribution. The delivery of care in this model should be very similar to a performance by an orchestra, with the hospitalist physician being the composer, the case manager being the director, and all the other varied and diverse healthcare team members playing their individual instruments. The hospitalist has written the music and the case manager makes sure that each member plays his or her part in time and in tune. This idealistic picture can and does exist in those places where hospitalists and case managers have discovered their common objectives and have performed as one on behalf of their patients and the organization. It is the perfect partnership.

Cogent Healthcare is among several companies that provide inpatient hospitalist services. They believe so strongly in the hospitalist–case manager partnership that they provide "clinical care coordinators"

(CCC) who are dedicated to the hospitalists in their client hospitals. Cogent has recognized that by providing CCCs to collaborate with their hospitalists, they have decreased the physician burnout and turnover rate. The CCCs help the hospitalists in the daily management of their patients by dealing with process and business issues, obtaining patient histories from the PCP, communicating with patients and families, coordinating the delivery of care and services across disciplines, and keeping the PCPs informed of the patients' progress and any "landmark" events that might occur. Some of these landmark events are defined as life-threatening occurrences or diagnoses, patient/family conflicts, unplanned surgeries or complications, and transfers to alternate levels of care. Keeping the PCP informed is paramount to maintaining continuity of care for the patient and the physician in the community (Cogent, 2001). The CCC is also responsible for notifying the PCP when the patient is discharged and making sure that he gets the latest clinical information on the patient as well as a written discharge summary. The CCC is also involved in post–hospital follow-up by calling the patient at home to make sure the discharge plan is in place and is still appropriate. The CCC makes sure that the patient is compliant with the post–acute treatment plan and has arranged to follow up with the PCP.

Although many mature hospital case management programs have made the leap from the acute care environment to the community, it is not a consistent feature of many programs. Nevertheless, with so many patients being discharged earlier for less costly and less risky ambulatory follow-up, the issue of continuity is a growing concern. Hospital case managers can smoothen the process of continuity by collaborating with their community and payer counterparts to ensure a seamless handoff with all the relevant healthcare information made readily accessible.

The Illusive Connection

If there is a hospitalist in your organization who seeks to promote higher quality, more cost-effective patient care while maintaining the satisfaction of the hospital, the PCP, consulting physicians, the patients, and the patients' families, and you, the case manager, do not have a working partnership with him, go........no, run to your director and plead your case. Be prepared to extol the virtues of having the case manager partner with the intensivists or hospitalists on staff. At the same time, be prepared to identify all the obstacles that may thwart partnerships from forming and suggest how these obstacles might be overcome.

In many hospitals, an effective case manager–physician partnership is not always present. Although case managers routinely report they have "good relationships" with members of the medical staff, when the same question is asked of the physicians, the response is politely couched in affable terms of fellowship—a far cry from the partnership that physicians' crave. Many case management programs found in hospitals today are really only window dressing. The structure of the department probably evolved from combining traditional utilization review and discharge planning functions. In this role, much of the case managers' dealings revolve around accomplishing the burdensome tasks related to utilization review and discharge planning activities. The case managers probably spend much of their time everyday performing tasks that do not require their professional license or clinical expertise. A great deal of the day is spent on the phone, over the FAX or copy machine, or negotiating for internal and external services. Many case managers see themselves as "surrogate mothers" to many of the dysfunctional delivery-of-care systems that exist within hospitals. The case managers beg, bargain, poke, prod, and cajole to get things done so that the patient can move through the inpatient continuum as quickly as possible. It is a daily exercise in frustration. The case managers find themselves addressing the same issues on a daily and ongoing basis. Meanwhile, the physicians are separately rounding and making clinical practice decisions that the case managers, had they been available, may have otherwise influenced at the point of care. If the case managers are to partner with the physicians, they must divorce themselves from the mundane tasks that occupy so much of their day. In this type of environment, both structural and operational barriers diminish the case managers' accessibility and their opportunity to cultivate a commanding partnership. If reaching out to the members of the medical staff and engaging them in the process of effective care delivery is an expectation of the case management program, the organization must provide the resources to support the case managers' work activities and demand accountability and responsibility from every service provider department.

Once the case managers are free of the most tedious, time-consuming clerical tasks, how do they she become a partner to the hospitalist? Chances are, the same things that frustrate the case manager are also huge hassles for the hospitalist and all physicians. The hospitalist or the attending physician arrives on the patient care unit assuming that all the diagnostic tests and treatments have been completed and reported so that he can continue to make clinical judgments and decisions on his patients' behalf. If those clinical tools are unavailable, he will most likely go back to his office and not be seen or heard

from until the next day. Remember, the independently practicing physician has historically had little concern that the patient now might needlessly spend another potentially avoidable day in the hospital. He wants to get back to his office where his time is more productive and profitable. Also, remember that for the physician in private practice, time is his most valuable asset. Although the physician is concerned about his patients in the hospital setting, the meter is running and the pressure for him is to get back to his primary care setting where his time can be more productive. He has no patience when it comes to dealing with hospital inefficiencies and is, in many instances, perfectly happy to have his patient remain within the confines and perceived safety of the hospital. Unfortunately, the patient cannot rely on the nursing staff to proactively facilitate the needed communication with the physician, because they are generally busy at the bedside and miss the 15-min window that the physician is on the unit.

The scenario, however, changes when the physician is a hospitalist. The hospitalist is most likely receiving incentives for cost-effective clinical outcomes and is not at all happy that the patient might have to spend another day in the hospital because of systems barriers. Hospital inefficiencies are probably costing money and are skewing statistics that otherwise might result in more favorable incentives for the hospitalist. In our experience, the hospitalist will not blithely tolerate misplaced charts, absent reports, overlooked orders, or delays in procedure scheduling. Together with the case manager, they share the same lamentable concerns about unnecessary delays, which pave the way for a formidable partnership. It is incumbent upon the case managers to recognize this symbiosis, work to free themselves of burdensome clerical tasks, and build on mutual goals to form a powerful partnership—one where everyone will benefit, especially the patient. The case manager no longer has to compete with the outside interests of the attending physician. The hospitalist is onsite and available, and brings standardization and accountability (Zinberg & Furman, 2000).

Another asset of the case manager–hospitalist partnership is the onsite presence of a physician champion who has easier access to the influential members of the medical staff and the executive suite. Armed with objective data about the existing barriers to efficiency captured and quantified by the case manager, the hospitalist has the means to support his concerns and clearly demonstrate where the process problems lie. The hospitalist is well positioned to enlist imposing support and demand that process owners be held accountable for efficient delivery of care to reduce wasted dollars and days, both of which expose the patient and the organization to preventable clinical and financial risk (Ramey & Daniels, 2001). When the hospitalist and the case manager join forces to improve the delivery-of-care processes, meaningful change is more apt to occur and there is greater response and appreciation of the value that the team brings to the table. We have even come across a few executives who have expressed a renewed willingness to invest additional resources in the case management program because of the benefits the case managers' support brings to the hospitalist program. Assuming that the average hospitalist cares for 600 inpatients yearly and generates just a 10% saving over the average medical inpatient cost of $8,000, one hospitalist would reduce inpatient costs by $480,000 per year. That's powerful motivation to continue investment in the hospital's dynamic duo.

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A Look Toward the Future

The effect of the hospitalist on delivery-of-care processes, costs, and patient care outcomes will undoubtedly escalate as hospitalist programs mature. At an average salary and benefits ranging from $145,000 to $180,000, however, hospital executives will continue to demand a concomitant return on their investment. Studies in the literature are beginning to appear, confirming some of the original predictions of lower costs and lower length of stay. The research is insufficient, however, to state that quality has significantly increased, although a few studies report decreased mortality and decreased readmission rates. According to statistics from Baptist Hospital in Pensacola, FL, a leader in the hospitalist movement, their program demonstrated the following:

- a 33% decrease in cost per case
- a 31% decrease in the average length of stay
- satisfaction ratings of 99% among physicians and patients
- a decrease by more than 60% in the 30-day readmission rate (Greeno, 2004)

In another study at Western Pennsylvania Hospital:

- median length of stay decreased from 6.01 to 5.01 days

The perfect partnership is not an unrealistic goal, but will take serious rethinking and redefining of the role, the structure and operations of the department, and the desired outcomes of case management efforts within the organization.

- median cost of care decreased from $4,139 to $3,552, and the
- 14-day readmission rate decreased from 9.9 to 4.64 readmissions per 100 admissions (Diamond, Goldberg, & Janosky, 1998).

Many areas within the hospital are ripe for improvement and intervention and in hospitals where reimbursement is largely case rate (DRGs), hospitalists are taking the lead in addressing throughput and capacity issues. Some have chosen to tackle quality and patient safety issues, while others have been at the forefront of developing pathways and protocols. Others have worked toward educating and improving relationships with the nursing staff. Many hospitalist programs now offer 24/7 coverage. At the University of California San Francisco (UCSF) Medical Center, one hospitalist recognized the need to address end-of-life care issues and developed a palliative care program, while one of his colleagues brought discussion of medical errors into an open forum with the medical staff (Gray, 2003). The case managers can and must assist in identifying and actively participating in these quality improvement initiatives that, in the end, will enhance their contribution to the organization's bottom line.

The perceptive case managers will quickly identify the advantages of this partnership and do all that they can to make it work. The perfect partnership is not an unrealistic goal, but will take serious rethinking and redefining of the role, the structure and operations of the department, and the desired outcomes of case management efforts within the organization. No matter what the final model looks like, the most fitting place for the case manager is at the hospitalist's side.

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QUERIES TO THE AUTHOR

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