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The Business Case for Hospital Case Management

Physician relationships, a growing number of hospital-based physicians, protective gatekeeping, promoting evidence based practice and overcoming delivery-of-care barriers are just some of the reasons to reinvent a hospital's case management program, say contributors Stefani Daniels and Richard Reece, M.D.

When case management was introduced in hospitals in the mid 80s, it was accompanied by a promise to control costs at the bedside. It was thought that the nurse caring for the patient was in the best position to manage and ensure the appropriate use of acute care resources with an eye for improving quality and reducing costs. The idea was admirable, but the execution was a dismal failure.

Over the years, especially with the re-engineering craze of the 1990s, the reduction in medical social workers and the rapid spread of 12-hour nursing shifts, which created continuity gaps, case management was relegated to nurses for utilization management and discharge planning activities.

Because their work was heavily centered on utilization review tasks, nurses became the "chart police" and the instruments for growing chart review activities, such as core measure abstracting, medical documentation review, concurrent coding assignments, safety indicators, and numerous other performance improvement projects. The idea of resource appropriateness, advocacy, navigation through the episode of care, cost reductions and improved quality vanished, except for an obligatory mention in the job description.

Recent incentives have returned the spotlight to the hospital's case management team. The desire to improve relationships with the medical staff, the continuing refusal of insurers to pay for non-acute services, growing regulatory pressures and the expansion of quality and safety measures are among the reasons why execs are rethinking how valuable and scarce professional resources can be more effectively mobilized to fulfill their original promise.

From our respective positions, as a hospital case management consultant and as a physician interested in hospital-physician management, there are several issues that are contributing to this renewed interest in case management. For starters, there is a new understanding that to be effective, case management must operate along the entire acute care episode beginning with access-to-care, through care management/through-put and capacity, and ending with transition to a lower level of care or discharge back to the community.

Furthermore, recent C-suite chats regarding traditional utilization review activities indicate executives are questioning the value of committing professional resources to perfunctory chart review when they might be more beneficially positioned to work alongside the physician to potentially influence decisions *before* they are committed to a medical record.

This is a relatively new phenomenon measured by the increased calls we get directly from C-suite occupants. They intuitively know that their case management programs have to be redesigned so that

a case manager is placed at the bedside with the physician who, after all, controls 80 percent of all clinical costs and whose decisions directly and indirectly effect patient quality and safety.

The explosion of employed hospitalists is another reason many execs cite to explain why they need help to transform their case management program. As contracted employees, hospitalists often have economic incentives based on quality and financial outcomes. We are frequently asked how to create partnerships that allow the physician to concentrate on managing care while the hospitalist's case management partner concentrates on the business of managing care.

Another driving force is the issue of effective gatekeeping. Access-to-care functions are so fragmented in the average hospital that financial officers find themselves budgeting more and more personnel to post-event fixes in the form of reversing admission status designations, denial management, appeal processes, revenue cycle coordinators and the like. Consolidating all access-to-care functions under a single administrative umbrella, using case managers and social workers in the emergency department and creating a single, consistent case management process for direct, transfer and emergency department inpatient referrals are among the objectives that find their way into our portfolio.

Physicians have been increasingly challenged as consumer knowledge of available treatment options has increased over the years. Public awareness of new treatment interventions and research findings have steadily increased through the media including screaming headlines citing failures.

While the demand for evidence-based medicine is growing rapidly, medical staff acceptance remains tenuous at best. Physicians need reminders to put post-MI patients on beta-blockers or to prescribe aspirin for patients with coronary artery disease. As long as physicians are reimbursed independently from the hospital, the benefits of a level quality playing field are lost. Physician practice decisions affect the hospital and the patient but have little or no economic or credentialing repercussions for the private physician. Unless there is blatant and persistent disregard for the well-being of the patient, hospitals are loathe to strip a physician's credentials for fear of litigation and the loss of a patient referral source.

So, what's a hospital to do? Chief medical officers look to case managers to work with selected physicians on a real-time basis to inform, educate, and counsel at the point-of-care. I've been told that using objective and comparative practice data coupled with a dedicated case manager works wonders for the obstinate physician.

Flawed delivery-of-care systems are often cited as examples as the inefficiencies that physicians and patients encounter daily. There is general consensus in the C-suite that they want a case management program that will overcome delivery-of-care obstacles so that length-of-stays are appropriate. Unfortunately case managers have no positional authority to streamline delivery-of-care processes, but they are quite knowledgeable about how hospitals operate. They know, for example, that physicians will order stat lab tests because turnaround time for routine requests will delay a patient's treatment plan. Case managers know that unless a PT consult is written on day one of a orthopedic admission, waiting for a rehab consult may add unnecessary acute, inpatient days.

Obstacles to efficiency are everywhere, but little accountability exists to remove or at least minimize them. While case managers are busy trying to expedite key delivery-of-care processes on behalf of the patient, they are also capturing objective information that they will present to the decision-makers about how much a particular barrier to efficient delivery-of-care is costing the hospital in terms of financial risk (lost reimbursement) or clinical risk (excessive length of stay). At that point, it becomes a business decision made by the exec team whether to hold the process-owners accountable for redesigning their internal systems to better meet customer needs.

Physician relationships, a growing number of hospital-based physicians, protective gatekeeping, promoting evidence based practice, and overcoming delivery-of-care barriers are just some of the issues cited by farsighted executives as reasons to reinvent their hospital's case management program. It's a far cry from the days of perfunctory utilization review and discharge planning, but it's still an illusive goal in many hospitals.

As chief advocates and patient navigators in a increasing complex and seemingly intractable healthcare system, hospital case managers deliver a return on investment in hard currency and stronger physician relationships. These valuable assets should not be squandered in a corner conducting chart review. Today's hospital case managers practice from an entirely different mental model then that of their predecessors and warrant closer attention and greater support.

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