Introduction

Even in the era of "full beds and no staff," hospitals have attempted to solve their capacity and human resource problems with more beds and more people. Hospitals turn to increasing their supply of resources, rather than managing their demand for care. More beds is a solution requiring enormous time and capital as well as regulatory approval in most states. More people is a solution that is near impossible in some labor markets. Many hospitals have underleveraged or ignored the importance of case management as a key strategy to driving clinical and financial performance through effective delivery of care. A strong case management program can markedly improve performance typically measured by metrics like hours of emergency department diversion, average length of stay (ALOS), outlier rates, complication rates, readmission rates, and home care referral rates. In concert, strong performance across all of these measures will drive better outcomes and continuity for patients while effectively managing the variable costs of care delivery.

The term case management carries different meanings within different realms of our care delivery system. Case management in a hospital looks quite different from case management in a community health program or an insurance company. This discussion focuses on hospital case management defined as a, not the, key driver of managing access to care, effective coordination of care processes, quality outcomes, and, in the end, human and financial resources. Case management involves an approach and an organizational attitude to achieving these ends, not simply a team of nurses and social workers with the job title "case manager."

Commit & Deliver: Organizational Leadership

Successful hospital-based case management programs are rooted in a leadership commitment to delivering high-quality outcomes in a cost-effective manner. While many hospital mission statements reflect verbiage to this effect, fewer actually practice and deliver to this end. In 2003, hospital CEOs, CNOs, and nurse managers should know their average length of stay and cost per adjusted discharge on a monthly and weekly basis, if not on a daily basis. As mentioned previously, an array of quality, utilization, and financial metrics can reflect the effectiveness of a case management program. Progressive organizations target levels of performance in their annual strategic goals with respect to these metrics. In addition, relevant members of the leadership and management team are held accountable and given incentives to achieve these targets. With these organizational priorities, leaders can focus on the work of departments and caregivers who directly affect performance. Performance improvement efforts are then prioritized to focus on these metrics and financial resources are brought to bear in these areas. For example, department managers work together to improve communication and department service timeliness. In these organizations, leaders effectively carry out their responsibility to make the mechanics of the hospital work well for the benefit of patient outcomes and patient satisfaction as well as of service to their physician partners.

Just as administrative leadership commitment is key to a successful case management program, medical staff leadership and individual physician accountability are paramount. Progressive physician leaders understand and value the relationship between quality outcomes and length of stay. In other words, patterns of prolonged length of stay can be a symptom of poor quality care that causes complications to occur or slow decision making that allows complications to occur. The Institute of Medicine and others have demonstrated the unintentional dangers associated with hospital stays. The current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards specifically describe the
responsibility of the medical staff to examine variant utilization patterns. The medical executive committee should be as aware of performance metrics as the board of directors.

Many organizations use a team of physician advisors (PAs) to oversee quality and utilization management issues related to physician practice. PAs serve as resources to case managers who are dealing with specific patient situations. Through weekly meetings and daily conversations, PAs can intervene with peers in difficult cases. Ideally, PAs are involved in cases within their specialty. Traditionally, hospitals have a utilization management committee that meets monthly to review data or historical cases. While retrospective analysis of patterns is important in identifying the need for program improvement or interventions with performance outliers, it does not support the resolution of care delivery problems that affect patients today. In addition, case managers benefit from real-time support of PAs intellectually and emotionally. They can further their clinical knowledge by working closely with physician colleagues, adding to their credibility when interacting with other members of the medical staff. Effective PAs also coach case managers on approaches that will be best received by a physician colleague. Since case managers are typically functioning in a fast-paced and high-pressure environment, PAs can mitigate some of the daily chaos associated with the role and provide a sense of organizational support.

As for the "rest of the organization," staff nurses, ancillary clinical departments, and other support services can help sustain the momentum of case management efforts. Obviously, bedside nurses possess the most current information about patient condition and progress. They should also have information about their patients' status prior to admission and a sense of their likely condition at discharge. Effective case management occurs when the bedside nurse internalizes and is held accountable to play a role in the case management and discharge planning process. The case manager and bedside nurse create a daily routine of conveying key aspects of the patient's severity of illness, intensity of service, plan for care, and other social influences that may effect progress and discharge. Just as the PA offers support to the case managers, the case manager can be a support and a role model to the nurse. Similarly, clinical professionals such as pharmacists, and respiratory, physical, occupational, or speech therapists are key to sound interdisciplinary care delivery and can play an influential role in case management outcomes. Service turnaround metrics for laboratory, radiology, and pharmacy departments should be routinely monitored in the context of case management effort. To provide timely data, to make timely decisions, to administer timely treatment, these departments must deliver services in a matter of hours or minutes, not days.

Who, What, Where: Organization of Personnel

An organizational commitment to case management sets the stage for success. However, clear role definition, consideration for the best model for patient assignments, appropriate workloads, and selection of personnel are equally important. Just as the term case management has various definitions within health care, the job title of case manager is associated with different duties from hospital to hospital. These duties may or may not include functions such as utilization reviewer, case facilitator, quality manager, discharge planner, and home health care liaison. In an era where duplication of work is financially infeasible, defining case management to include all or most of those functions is preferred. For example, if utilization review is performed by one role and discharge planning is performed by another, approximately 75% of the information about a particular patient required to perform the function is the same. In addition, the various personnel must interact with the hospital and medical staff to cover overlapping issues requiring repetitive work for other caregivers. The more personnel involved in coordinating care, the more opportunity for miscommunication and breaks in continuity. That said, discrete aspects of those functions can be delegated to other personnel to better leverage the time and skill of case managers. For example, once the determination is made that a patient requires durable medical equipment or transportation at discharge, it does not require a masters in nursing or social work to perform the travel agent functions.

By Unit, By Diagnosis, By Physician, By Payer

Defining the best model for patient assignments should be highly customized to the institution with consideration given to patient demographics, physician practice patterns, payer mix, and other organizational idiosyncrasies. Models that have been successfully implemented include assignments by patient care unit, diagnosis, physician, and payer.

Assignment by unit is most common, particularly in mid to large-sized hospitals because patient units typically care for patients with like diagnoses. The advantages of this model include additional work efficiency due to geographic proximity, but more importantly, the benefit of establishing solid working relationships with the nursing and ancillary staff working on the unit.

Models assigning patients by diagnosis enable the case manager to develop expertise in the diagnosis, treatment, and expected outcomes of particular diseases and conditions. This expertise enables the case manager to provide more valuable information to patients in order to support their decision making and manage their expectations of their hospital and post-acute care experiences. This expertise also supports the credibility of the case manager with physicians.

In some organizations, patients are assigned according to attending physician. This approach emphasizes physician communication and relationships through a partnership and service orientation. In organizations where a traditional utilization management and discharge planning approach has been used, the relationships between these staff and physicians can be characterized as adversarial. Physicians often feel hassled rather than helped by the "nagging UR witch." A physician-centric case management model can help an organization effectively transition into a more contemporary approach for managing care by approaching physicians with a mentality emphasizing personal service. When performed effectively, physicians find this approach invaluable. Once a more constructive and cooperative relationship is establish, true partnerships can evolve that reflect the unique and indispensable roles of the physician and case manager.

Assignment by payer type has also been used successfully in organizations with unique payer issues such as payers with intricate reimbursement mechanisms like capitated managed care contracts including carve-out patient populations or burdensome utilization management requirements like worker compensation. Another example includes institutions with a high percentage of patients with pending Medicaid coverage.

Many institutions have combined these models for the most effective approach. For example, the majority of their case managers may be assigned by unit with a few assigned to specific physicians. Physician-assigned case managers have been particularly effective with high-volume surgeons who would prefer to be in the operating room than on the floor. High-volume physicians can practice with poor utilization patterns simply by virtue of an overwhelming workload, not because of slow or careless decision making. In this instance, a case manager can function in a physician extender-like role by rounding on patients in advance of the physician, gathering all the necessary data to facilitate decision making, drafting discharge plans, and then physically round with the physician to focus him/her on the decisions affecting the progression of care. This model is also effective with physicians who have poor interpersonal skills with patients and nurses or who simply can't say "no, you can't stay another day" to little old ladies.

Workload Distribution

In general, a case manager can handle a load of 25 patients. This workload is best handled when a case manager works in collaboration with some support by a social worker. For example, two case managers may be responsible for a population of 50 patients with orthopedic and neurologic diagnoses. Working as a team, the case managers can oversee all patients and the social worker can focus on patients with complex social, emotional, or placement needs. Obviously, the model for assigning patients influences the assignment of work to individual case managers. For example, a case manager responsible for a population of young patients hospitalized for elective short-stay surgeries can manage a larger workload than a case manager responsible for a population of medically complex elderly patients or a case manager...
following a patient population without insurance coverage.

Fit

While physicians are experts in understanding the condition faced by their patients, they are rarely experts in understanding the constellation of variables that play into a discharge plan. Personal preference, family, venue, equipment, payer, and unfortunately, paperwork are just a few issues that determine a discharge plan. That said, not every nurse makes a good case manager. Effective case managers have 3 to 5 years of direct care experience, preferably within the specialty area in which they case manage. The best case managers are extremely bright, are interpersonally gifted with patients and families, and have collegial communication skills with staff and physicians. Like any role in nursing, the skills to multi-task are a must. They must acquire a strong foundation in principles and criteria of utilization review. Within a particular institution, they must have the ability and the information to have a working knowledge of area facilities and providers of post-acute care and they must understand the intricacies of payer-specific patient benefits and hospital reimbursement mechanisms. Case managers who love their role typically enjoy the challenge of bringing needs, preferences, and payer choices together for a safe and effective discharge plan. Case managers who found themselves unhappy in their role, often expected a role that is easier and slower paced than bedside care and have been unpleasantly surprised.

In fact, case management is a recognized specialty in nursing. The Case Management Society of America was founded in 1990 to create a community for professional development and networking as well as to advance legislative concerns. A certification program exists to certify case managers that is administered by a separate organization, the Commission for Case Manager Certification. The credential, Certified Case Manager (CCM), addresses "six essential activities of case management: assessment, coordination, planning, monitoring, implementation, and evaluation in multiple environments." These "environments" include "process and relationships, health care management, community resources and support, service delivery, psychosocial intervention, and rehabilitation case management." The CCM credential has been awarded to over 26,000 individuals. The criteria for certification utilize a Scope of Practice and Code of Conduct. Case management certification is not necessary to develop a high-functioning and effective department, but the support these professional resources provide may be quite useful.

Block & Tackle: Basic Tools and Routines

Regardless of how all of the previously mentioned variables take shape in a given organization, several principles regarding everyday practices should be noted that will ultimately result in high-quality and low-cost outcomes. First, the case manager must review every case every day. The process of case review involves a combination of examining the medical record and seeking out new test results. Conducting some form of interactive rounds with the nursing staff and other relevant clinical disciplines should occur daily. These routines enable the practice of day one discharge planning. Many organizations only conduct rounds on a weekly basis and miss the opportunity to better understand current response to treatment and to organize team efforts to move a patient and family physically and emotionally toward a desired goal. In some cases, other members of the interdisciplinary team may be more effective in dialogue with patients, family, or physicians in achieving the desired outcome. This team approach reflects the unique needs of every situation and holds all disciplines accountable for achieving outcomes. Providing some level of case management service on the weekends can significantly improve capacity management and length of stay. Given that physician and ancillary services are often provided at lower levels on the weekends, case management services can be provided at a lower level. Keep in mind that hospitals that do not provide 24/7 service for every aspect of care are able to achieve a low length of stay. The availability of services should be factored into care planning by prioritizing discharge-pending tests during limited hours of services. In organizations without weekend coverage, an analysis of length of stay by the day of week that the patient is discharged will often reveal that patients discharged on Mondays have an ALOS 1 to 2 days greater than patients
discharged during the rest of the week.

Routine communication with physicians is critical to building partnerships. Case managers should avoid leaving notes on the chart reminiscent of "UR Love Letters." Ideally, the case managers know the routines of the majority of the physicians responsible for their patients and make themselves available when physicians round on their patients. If direct contact is not feasible, the case manager should gather an updated picture of the patient's current condition and future needs. They should be prepared to provide a concise summary, key questions to anticipating future needs or resolving issues, and a set of options in anticipation of discharge. Communication strategies that focus on patient needs and service to physicians are often most successful. Use of traditional utilization review language like "your patient doesn't meet criteria" will often be met with resistance. While the patient may not "meet criteria," the dialogue should focus on "I can be of help to you and your patient to find the best place for care."

Case managers often serve as the eyes and ears for many areas by collecting data for utilization review, quality assurance, medical records, and risk management purposes. Often the data collection burden placed upon a case manager can take away time better spent working with patients, families, staff, and physicians. Each element of data collected by a case manager should be critically examined to see if the data are truly necessary or can be found using other less-costly personnel or information systems. For example, the JCAHO requires organizations to evaluate patterns in utilization of resources. Fulfillment of these standards does not require a case manager to collect data regarding "avoidable days," even though these data may be useful to some organizations. Rather, reports provided by Medicare, Medicaid, or other payers provide feedback about denial rates and other utilization issues related to appropriateness of admission and continued stay. Most hospital information systems will provide LOS reports by diagnosis, nursing unit, and physician. Other strategies to leverage the time of case managers include delegating travel agent and clerical functions to other nonnursing staff. Case managers and social workers can lose productivity with tasks like faxing forms and copying charts prior to transfer, filing paperwork, and arranging transportation or equipment for discharge.

Providing case management staff with appropriate tools equips them with valuable resources and clear expectations. With a daily census list reflecting actual and expected length of stay, case managers can organize the required care to be delivered in a reasonable time frame. Targets for expected LOS and clinical outcomes should be provided annually based upon national benchmarks and organizational priorities. Other valuable resources include a summary of payer-specific expectations for utilization review as well as a description of reimbursement mechanisms. When staff nurses and case managers understand how Medicare reimbursement works, they are able to focus and apply their knowledge of providing the right care to patients at the right level of care in a manner that benefits the patient and the institution. Ensuring that the case managers and social workers are equipped with accurate and complete insurance information from the point of admission can save significant time. Discharge plans are driven by the choices afforded by individual payers. Patient expectations are tied to the choice of certain facilities. If inaccurate information is gathered by admitting personnel, the staff have frustrated a patient, hindered productivity, and ultimately prolonged LOS.

Creating fluid working relationships with post-acute care providers improves continuity for patient care and improves the productivity of case managers and social workers. Forging these relationships may require administrative intervention to start. Long-term care or home care providers should be cognizant of the referral volume that they receive from any given hospital and should be willing to offer flexible service in the form of accepting admission after 2 pm or on the weekends if necessary. Discharge planners with a traditional mindset often express concern about unethical practices like limiting patient choice or steering referrals to exclusive providers. Efforts to strengthen relationships with a group of providers are not meant to limit patient choice, rather to offer patients choices that are more service oriented and can offer patients better continuity with their physician and acute care provider. Consider the post-acute care needs of a patient who has experienced hip replacement. Twice-daily physical therapy is difficult to achieve in some acute care settings. This level of intensity helps drive the best possible patient outcomes and most rehab or home care providers prefer patients with more intense skilled needs. In this scenario, orthopedic surgeons can establish standing orders that carry a patient from
postoperative day 1 through complete recovery to independent living. Building clinical continuity between venues to benefit the patient should not be confused with steering referrals. In the spirit of patient advocacy and choice, few patients desire to wade through a list of 50 providers with no additional guidance about care quality, service, or outcomes. Building relationships with post-acute care providers enables the case manager or social worker to advocate for patients by providing more information about demonstrated quality, service, and outcomes delivered by specific providers.

Summary

Several strategic, organizational, and operational variables drive successful case management programs. Organizational goals and accountability for support by administrative and medical staff leaders set the stage for a comprehensive program. The integration of utilization review, discharge planning, and other functions into the role of the case manager improves productivity and continuity. Choosing a model for assigning patients, a variable unique to the institution, should be carefully considered. Regardless of the power of strategic goals or the creative selection of a model, daily practices that promote daily review and communication will reveal all of the opportunities for improved performance. Complications are avoided one patient at a time and patients deserve vigilance. Length of stay is shortened 1 day at a time and we can no longer afford to miss these opportunities. In the period of high census, an unnecessary day for one patient at the end of his/her stay may mean another patient being diverted to another hospital away from his/her physician and past medical records. Creating constructive physician partnerships and cooperative relationships with post-acute care providers can bring a case management program to higher level of performance. While many organizations have employees called "case managers," fewer have a comprehensive approach that has the potential to drive so many important indicators of performance.

Sidebar: Executive Summary

- Many hospitals have underleveraged or ignored the importance of case management as a key to driving clinical and financial performance through effective delivery of care.

- Comprehensive case management programs can be a key driver in delivering high performance in the form of capacity management, quality outcomes, length of staff, and cost per case.

Reprint Address

Comments and suggestions can be sent to alisonpaigesmith@aol.com

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