CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

C-Suite Executives: The Final Frontier for Hospital Case Management

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Introduction

Hospital case management is finally coming into its own. Administrators are beginning to understand and recognize the value that case managers can add to the interdisciplinary care team. Unfortunately these are often middle managers such as directors and assistant and associate vice presidents. Many "C-suite" executives are still struggling with understanding and appreciating the value that case managers and social workers bring. So, who are the residents of the C-suite? They include the "chiefs": the chief executive officer, chief operating officer, chief financial officer, chief nursing officer, or the chief medical officer, among others. They are the most senior members of the hospital staff and they control the final decisions made across the hospital's systems and patient care areas. They control the purse strings and the long-range vision of the organization.

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The C-Suite Is Critical

If we think of the hospital as the "bus," then the C-suite is the "driver." The C-suite must know the destination as well as the road that needs to be taken to get there. They need to know the cost and the obstacles in the way. Finally, they must be able to understand the current marketplace as well as the future market. This need requires a vision and an understanding of what is ahead and how it can be planned for strategically.

The Centers for Medicare & Medicaid Services (CMS) are in a constant state of change. These changes are coming at faster speeds than ever before and require constant diligence to remain aware of what is happening, what is new, and how the issues are interconnected. These changes involve how we deliver care as well as how we get paid for it. CMS has moved from being a passive purchaser of health care to an active consumer of health care services. In the past, Medicare had paid most hospital bills with little question. Readmissions were paid for, quality of care was not routinely questioned, and levels of care were not scrutinized.

Value-Based Purchasing and Outcome Measures

Among the many changes imposed by CMS, value-based purchasing has probably been the biggest game-changer. For the first time, quality outcomes and reimbursement became dynamically linked. In federal fiscal year 2013 (which began in October 2012), the accountable core measures, patient experience scores (HCAHPS), readmissions and hospital-acquired conditions (HACS) became linked to how we received reimbursement in terms of penalties or reductions in payment.

The mortality measure was added in federal fiscal year 2014 (October 2013). This measure linked patient deaths to payment penalties for hospitals that had greater than expected mortality rates within thirty days of admission to the hospital. The death could occur anywhere across the continuum of care. The first diagnoses included mirrored the readmission diagnoses, and included heart failure, acute MI and pneumonia.

In federal fiscal year 2015 (October 2014) CMS added the patient safety indicators, central line-associated blood

stream infections (CLABSI), and the efficiency measure. The efficiency measure has significant impact on case management because it measures cost and length of stay against national averages. It requires that hospitals take much greater measure and scrutiny of the resources that are consumed by patients beginning three days prior to admission and continuing until thirty days post-discharge.

Adding to the complexity of the measures are the bundled payment pilots. These pilots allow some hospitals to bundle all, or portions of a diagnosis, into one payment. This concept shifts more risk to the hospitals as it requires the hospital to manage resource consumption not just in the hospital, but in the community as well. For example, a knee replacement patient might require sub-acute rehabilitation or home care after discharge from the hospital, and this cost would be bundled into the payment. Not unlike the readmission penalties, the bundled payment methodology links services across the continuum in terms of resource consumption and reimbursement.

What Does this Mean to the C-Suite?

In addition to CMS requiring hospitals to measure against clinical processes and outcomes of care, the new measures now require acute care settings to think beyond the hospital walls. This concept is new to hospital administrators in many ways. Under traditional Medicare prospective payment methodology, the hospital was paid for discharges, with very little question as to their initial appropriateness or necessity. While hospitals were required to review admissions, this was more of an "honor system" as Medicare was not auditing hospitals at that time.

The traditional notion of "growing the hospital" with more and more discharges is changing, however. Most hospitals have grown discharges by adding more physicians to their ranks. More physicians meant more admissions and discharges. In healthcare's future state, more physicians may mean more difficulty in managing resources, length of stay, and readmissions adequately.

It truly is a schizophrenic time for health care administrators as they live with one foot in one world, and one foot in another. How do they implement readmission reduction strategies, when you are only penalized for three diagnoses and rewarded with payment for all the others? How do you keep the hospital afloat while you prepare for the future state, and get paid for the current one? These questions are not easily answered. They raise the stakes for success to much higher levels than an administrator had to face even ten years ago.

Preparing for the Future

The challenge described above is a complex one. Hospitals and health care systems must prepare one-year, three-year, and five-year plans that incorporate new care models. These models must roll out over time and as the CMS rules include more diagnoses and more levels of care. **At the center of all this must be case management.**

This first challenge then is to educate senior leaders as to the differences between utilization review and case management! Most senior leaders have many years of experience, but their earlier experiences may have been with the early use of utilization review. When utilization review morphed into case management, many organizations continued to use the old models and nothing changed but the job titles. Many did not re-engineer their departments, change staffing ratios or even job descriptions. For these senior administrators, the value of case management in today's changing environment is not clear. Also not clear is how case management may assist them in transitioning to new models that may take years to achieve a return on investment (ROI).

In Some Ways the Rules Have Already Changed

Several of the Inpatient Prospective Payment System (IPPS) rules have already changed the nature of the business. Among these is the two-midnight rule. Many hospitals "banked" on receiving an excellent reimbursement for their one-day stay discharges. In some cases, up to 40% of discharges could be one- and two-day stays. These patients were usually less complex, had few discharge planning needs, and their DRGs (diagnosis-related groups) paid well.

It wasn't surprising that CMS caught on to this and began tracking these patients. This tracking eventually resulted in the two-midnight rule, which resulted in patients with a projection of a one-midnight stay only having to be placed into observation status. This meant a number of things for the hospital administrator. First, projected discharges affecting the hospital budget had to be recalculated. Secondly, this recalculation resulted in significant reductions in reimbursement, as

observation status pays much less in the aggregate than a one-day stay had previously paid.

The solution? Case management in the emergency department! ED case managers can assist physicians in determining the correct level of care, and can also work on facilitating discharge or transitional planning from the ED when appropriate. Case managers can also manage the patients placed in observation so that the period of observation can be optimized by fast-tracking these patients through diagnostic tests and interventions. So whereas before, administrators were concerned that ED case managers might turn away "paying customers," now ED case management is a necessity for the future survival of the hospital.

Other Value-Added Points for Case Management in the Hospital

Hospital case management has become much more complex than just a means to provide discharge planning and call in clinical reviews. Case managers, if staffed adequately, can be a resource for managing patient flow and resource consumption. Patient flow requires that the case manager intervene when there are delays in patient progression, ensuring that the patient has a smooth movement through the hospital stay. It can be argued that no one else on the interdisciplinary care team is focused on these issues as greatly as the case manager is, or can be.

Expanding the role of the case manager to include patient flow adds value to the role and helps the hospital in achieving a variety of outcomes, including cost reduction and cost avoidance. Because cost avoidance was always hard to quantify, this role was not always highly valued. However, with the "Spending per Medicare Beneficiary" measure, hospitals will be able to see true outcomes from these interventions.

The greatest talking point for hospital case management, then, is its contribution to lower costs, higher quality and improved patient outcomes. Case management must be integrated with the current care continuum as well as the future state care continuum. As mentioned above, this is challenging, but it can be done!

How to Create the Care Delivery System of the Present and the Future

Case management must be at the table while planning the models of the present and the future. So, how do we get there? Meet with your executive and bring talking points, evidence, and a plan of action.

Here are some examples of the talking points you might work on:

1. Current care delivery model
2. Future care delivery models
3. Best practice roles, functions and caseloads
4. Current payment models
5. Future anticipated payment models
6. Conditions of Participation for discharge planning and utilization review
7. Quality metrics, including value-based purchasing
8. Care processes and patient flow
9. Use of case management in the emergency department
10. Current Spending per Medicare Beneficiary score
11. Current readmission rates for Medicare, Medicaid, and commercial payers

Put these into an easily readable report card format for discussion. Add literature as necessary to support your case.

Next, recommend the development of a multidisciplinary task force to work on these issues. Included should be a team of administrators, clinical leaders, finance staff, medical staff, nursing leaders and emergency department leadership. While case management plays a part in all of these issues, be sure to make the point that all departments and disciplines ultimately impact on these interventions and outcomes as well.

The main purpose of the task force should be to develop a business plan that incorporates a structure to respond to the current environment and a roll-out plan for the next few years. They should focus on the details and implications of the current efforts in place and then begin to prepare for the future state.

Developing the Business Plan

The team should begin by conducting a gap analysis. The analysis should be based on gaps in the current care delivery model and action steps to correct them. From this, the group can then put the action plan together, outlining in detail what each action step should include, who will be responsible, and the time frames for completion of the step. The plan should also include any barriers or obstacles anticipated that may impede the completion of the step. These might include product or personnel resources, such as staffing. Finally,

the action step should include metrics for measuring and tracking progress.

Once the current state has been assessed and the action plan developed, the group should begin to turn its attention to the future state. Remember that all the interventions for the future state do not need to be implemented at once, but rather should be gradually introduced as the payment models and quality metrics begin to change. The team might want to consider beginning with specific patient populations that are managed across the continuum of care and in high volume in addition to those being focused on by CMS.

Infrastructure Is Key

Some of the major issues to focus on during the future state planning include:

- The case management model to be used
- Roles and functions of the RN case manager
- Roles and functions of the social worker
- Caseloads for the RN case manager
- Caseloads for the social worker
- Work flow and processes for each discipline
- Ancillary support staff
- Case management software support
- Expected outcomes and how they will be measured
- Table of organization and reporting mechanisms for the new structure

The answers to each of these questions should be based on "best practice" as defined by the case management industry. As the team works through each issue, they should be referred to the case management literature to help guide their decision-making. Hospital-based case management models have been tested for thirty years now, and there are models that are known to achieve the best outcomes at the lowest cost possible. Run a literature search online to obtain these figures if you don't already have them. In past years, it was not uncommon for C-suite leadership to drive caseloads based on old paradigms and old payment models. For this reason, it is critical that objective decisions be made based on industry best practices.

The most important elements are those listed above. If the model and staffing are not correct, the department will never achieve its expected outcomes. This is guaranteed!

"ANECDOTAL THOUGHTS AND OPINIONS WILL NOT GET YOU THE RESOURCES YOU NEED. BEST PRACTICE INFORMATION WILL BE A MUCH BETTER TOOL FOR MAKING THE CASE AND HAVING IT STICK."

Stay Current

My other recommendation is to stay current with the case management field as it continues to evolve. Ways in which to do this would include:

- Joining a case management professional organization. Most of these organizations will provide you with up-to-date electronic information on current issues and trends in case management.
- Subscribe to case management journals. Written publications will also give you up-to-date information. Consider broadening beyond the case management literature to include health care financial and regulatory information as well.
- Attend case management seminars. Meeting with colleagues from across the country that are challenged in the same ways that you are is another good way to keep your knowledge base current and get help in addressing your own organization's issues.
- Obtain a case management certification. Several of the case management organizations provide certification. This process not only helps you to stay current but also requires that you remain current going forward.

Summary

In order to sit at the table with your organization's leadership and make credible arguments and a sound business case for the resources you may need to move your department forward, remember that you need to be as well versed as you possibly can be. Anecdotal thoughts and opinions will not get you the resources you need. Best practice information will be a much better tool for making the case and having it stick.

With the changes that have been imposed by CMS and other regulatory bodies, the time has never been better for case management. Case management is one of the solutions to meeting the challenges to today's health care environment! ■