

Case Management – The Tie That Binds

The importance of using case management to navigate the reformed health care environment.

By

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Healthcare is entering its third watershed period in 35 years. Today the American Healthcare policy is being redefined. In 1965, President Lyndon Johnson helped structure the modern means of delivering health services by supporting the Medicare Bill. This Bill accomplished two purposes. First, it defined what the American public healthcare policy would be for the next three decades. Second, it established that the primary site of care would be the “hospital” and that the compensation structure would be a retrospective reimbursement system based on cost.

The second watershed period, in our recent social history, came in 1982 with the passing of the prospective payment system (PPS) and the introduction of diagnostic related groups (DRGs). DRG based payment essentially leveled the playing field of national compensation for services rendered to patients within an acute care hospital setting.

The greatest significance of this period was a change from a reimbursement system (retrospective) to a payment system (prospective) with little accepted variance from one facility to another and one region to another.

The third watershed period occurred most recently in August of 1997 with the passage of the Balanced Budget Act (BBA). As with the 1965 Medicare Act, the BBA focused on the venue(s) of service delivery and the means of compensation. The BBA was a key vehicle in Congress’ desired restructuring of Medicare.

THE REDEFINITION OF HEALTH CARE

The most significant impact of the 1997 BBA was its sole emphasis on the redefinition and restructuring of post acute venues, thereby supporting and promoting the continuum of care. The BBA not only defined post acute venues, their purpose and their reimbursement, the **BBA redefined acute care**. When reviewed in its historical perspective, the changes that the American healthcare system has undergone in the past twenty-four months appear less onerous. However, we are undergoing significant alteration as to the means of delivering health care. The BBA redefined the American public policy as to the sites of care delivery shifting emphasis from hospital based acute to multi-venue post acute care creating a seamless continuum. *This transition has put the provider at risk to have the patient in the appropriate venue at the appropriate time.*

With the onset of the prospective payment system in 1983, hospitals faced, for the first time in their history, benchmark expectations for length of stay dictated by diagnosis. The 1997 BBA has exacerbated the problem with shorter length of stay benchmarks for certain diagnoses thereby increasing the risk faced by hospitals in managing length of stay.

AN AFTERMATH OF PPS REVENUE LOSS?

As hospitals and health systems adjust to the watershed transition from a reimbursement form of payment to a prospective form of payment, there must be timely and consistent monitoring of the financial and operational impact of patients moving from one venue to another.

If and when the patient stays beyond the established length of stay, no additional payment is made to the acute hospital. This is referred to as **PPS Revenue Loss or uncompensated care**.

Over-utilization of the acute bed and untimely use of the post acute venue has resulted in an average revenue loss of \$20,000 - \$50,000 per bed, per year, depending upon hospital specialization, patient mix, available post acute venues and community practice patterns. It

is not unusual for a 200 bed hospital to experience a PPS revenue loss (or uncompensated care) of seven to ten million dollars per year if the hospital is not effectively and efficiently utilizing a full continuum of care.

CASE MANAGEMENT'S ROLE IN LOSS REDUCTION

Case management has been at the forefront of attention for the past several years as a key strategy in managing health care costs. A strong, well-organized centralized case management system is a key component in the optimal operation of a full continuum of care. Case management is a system designed to identify, coordinate and direct services utilized in the delivery of health care. The goal of case management is to place the patient in the right venue of care at the right time based on the patient's medical needs.

Case management should be viewed as the most effective means of reducing and controlling revenue loss and uncompensated care. In this way, case management is also the cornerstone for a hospital to respond to the changes in recent reimbursement legislation.

In a healthcare system, case management should be centralized so that all case managers utilize identical policies and procedures for patient care management. A successful case management system must have case managers who function at a common level of knowledge regarding care options, venue options, clinical goals, anticipated outcome and the regulatory and compliance implications involved with the various venues of care.

Systematic training of the case management team and up-to-date resource tools are essential components to effective centralized case management. Centralized case management is the primary tool for directing the patient appropriately along the continuum of care responsive to his or her medical condition. Case management is the key strategic operational tool for effective management of an integrated health system. It not only identifies the problem it helps to provide the solution.

One of the historic impediments to optimal implementation of case management, is the lack of a uniform system of data gathering and

analysis. This critical need is driven by shortened length of stay in acute care and the federal mandate to utilize more cost effective multiple care options available within post acute care.

Hospital and health systems have yet to optimize the effective use of multiple sites of care using decreased levels of resources in keeping with the declining medical needs of patients as they prepare to return home. Prior to the prospective payment system, there was only one level of care, that is the acute bed. However, patient care can actually be enhanced if medical resource allocation equals medical acuity requirements. Providing a higher intensity of care than is required may be an impediment to patient progress. The following table depicts the key variables of acuity which dictate resource intensity. The table also illustrates a comparison between the following key variable of each venue of care:

- Nursing hours
- Physician contact
- Patient stability
- Length of Stay
- Payment

Case management is the means of assuring proper allocation of resources comparable to need.

KEY VARIABLES
A MULTI-VENUE STRATEGY
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ACUTE

POST ACUTE

ACUTE		POST ACUTE			
ICU	ACUTE	LONG TERM ACUTE CARE	REHAB UNIT	SUBACUTE	CENTER FOR AMBULATORY MEDICINE
Avg. 19 direct nursing hours per pt / day	Avg. 8 direct nursing hours per pt / day	Avg. 8 direct nursing hours per pt / day	Avg. 5.5 direct nursing hours per pt / day	Avg. 4 direct nursing hours per pt / day	Avg. 1.5 nursing hours per pt /day
Daily (or more as needed) physician and consult specialist contact	Daily physician contact	Daily physician contact	Daily physician contact Average 5 days per week	Intermittent physician contact Avg. 3 days per week	Intermittent physician contact Less than 1 day per week
Patient's condition may change by minutes	Patient's condition may change by day	Patient's condition may change by week	Patient's condition may change by week	Patient's condition may change by week	Patient medically stable
Patient in crisis	Possibility for crisis	Possibility for crisis	Possibility for crisis	Condition nearly stable	Medical condition stable
ALOS 1-4 days	ALOS 3-5 days	ALOS 18-35 days	ALOS 10-22 days	ALOS 7-20 days	ALOS 2wks–10wks
Average per diem \$1800	Average per diem \$850	Average per diem \$850	Average per diem \$650	Average per diem \$300	Average per diem \$350

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CASE MANAGEMENT: TYING IT TOGETHER

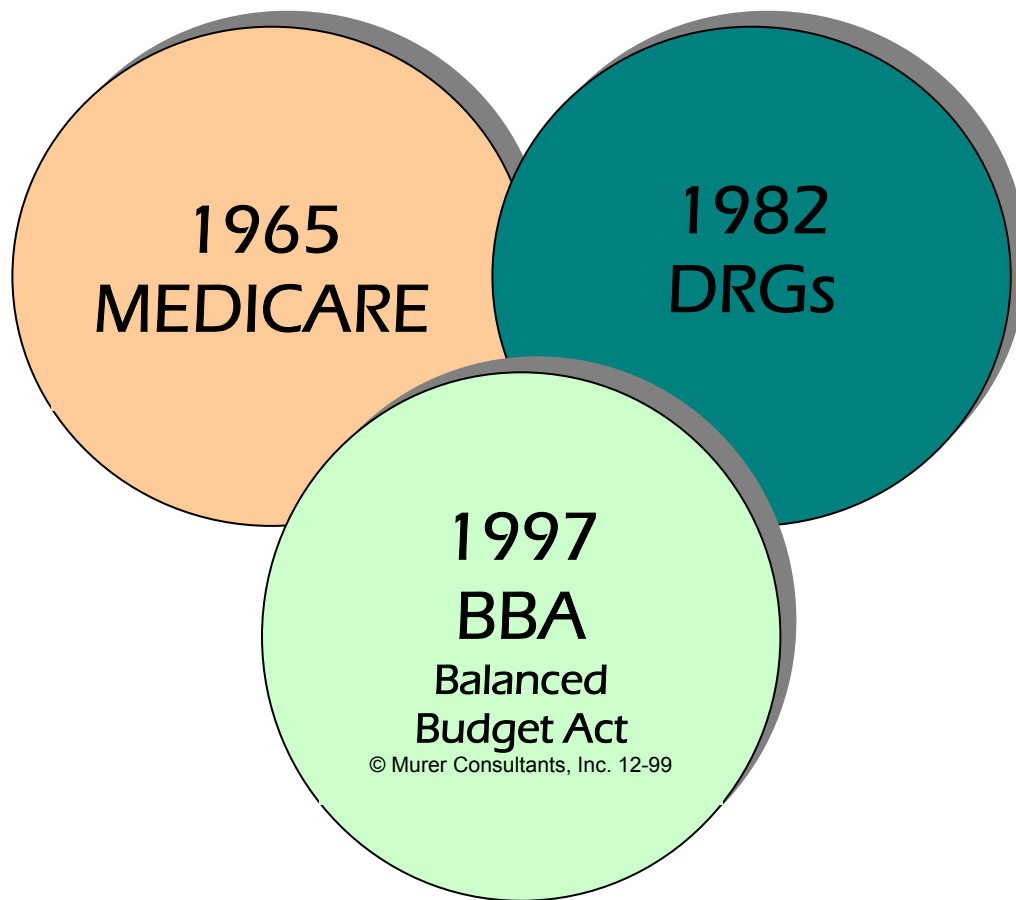
In this complicated healthcare system, case management is the process by which care delivery is assessed and guided. It is the primary tool to effectively serve patients with numerous and complex needs while simultaneously seeking to reduce utilization and costs. The sheer magnitude and diversity of healthcare options today compounded by increasing reimbursement and regulatory complexity has resulted in fragmented healthcare delivery. Issues of access, government bureaucracy, and limited health care dollars compound the problems. Case management has emerged as the necessary link to piece together and navigate our reformed health care environment.

About the Author:

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The Watershed Years



The American Healthcare Delivery System

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