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Can Case Management Help?

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From the Editor

Can Case Management Help?

Many observers would agree that under capitation and other new market realities, an increase in the coordination and efficiency of care would be welcomed. Efforts to reduce inpatient lengths of stay and inappropriate utilization of resources ought to be viewed as laudable ends unto themselves. Fifteen years of research on small area analysis, clinical benchmarking, and other important national research trends confirm beyond a doubt that opportunities to improve the clinical process reside in every institution. This may be especially true of large academic medical centers like TJUH. How then might we operationalize or achieve some of these laudable goals. Perhaps, one partial answer may rest with the concept of clinical case management. Before the wary reader condemns yet other jargon term in our medical lexicon, let's examine the latent potential of clinical case management and see how its broad acceptance may be beneficial to the institution. In the absence of a universally accepted definition of case management, let me offer mine. Case management is the clinically-based science which brings together the disciplines of utilization review, quality improvement, and the tools of non-punitive feedback on performance. It links all of this with the need for organizations to respond to the exigencies of the marketplace and to decrease the length of stay, decrease unnecessary utilization of resources, decrease miscommunication, and decrease opportunities for variances within the process of care.

Mounting evidence, especially within large group practices and nationally prominent health maintenance organizations, suggest that the role of the case manager can indeed improve the quality of patient care. Initial evidence from the hospital sector while not as dramatic, is indeed compelling.⁽¹⁾ A related science, the development of critical pathways of care (when linked to case management) may offer additional savings and improvements. Critical paths, the moment by moment description of what ought to happen within a specific diagnosis within an individual institution are one of the tools in the tool kit of the case manager. Critical paths enable an interdisciplinary team to sit around the conference room, and probably for the first time, share with one another their specific daily goals and objectives. The conversation often results in exclamations of "You really do that?" and "I had no idea that was happening." For many, the value of the critical path construction rests within those gratifying conversations. For others, the critical path is a lever to decrease the length of stay and improve efficiency. The truth probably lies somewhere in between.

So the question remains then, can case managers bring together the various disciplines noted above and use a tool like a critical path to make a difference in what happens at Jefferson. A small dedicated group of persons is trying to answer that important question today. Indeed, a case management steering committee, at the hospital level, composed of Alan Brechbill, Stan Smullens, MD, Mary Ann McGinley, RN MSN, Janet Burnham, and Eleanor Gates, RN MSN is establishing the goals and priorities for the hospital-wide case management program. Ms. Gates, as the first case management program director, is charged with organizing this interdisciplinary effort. The steering committee has chosen congestive heart failure (CHF) as the first patient population to participate in the case management process. Broadly speaking, persons with congestive heart failure will be identified and via an analysis of the variance in the process of care linked with case management, it is hoped that a decrease in the overall length of stay and improved efficiency of their

care will result. The case management steering committee oversees the work of the case management interdisciplinary design committee and three subcommittees including the critical path work team, the variance work team, and the program evaluation work team. Dozens of TJUH professionals are involved in all aspects of this work including representatives from nearly two dozen hospital departments ranging from utilization management and quality assurance to nursing, internal medicine and medical records.

Why did the steering committee pick congestive heart failure as its first experimental case management program? Clearly, cardiovascular disease still accounts for approximately 40 per cent of the annual deaths in United States,(2) and ischemic heart disease continues as the number one cause of death in both men and women. Mortality from congestive heart failure is comparable to that of many malignancies. The majority of patients with congestive heart failure require treatment with a diuretic, although now there is clear evidence that the addition of an angiotensin converting enzyme (ACE) inhibitor will not only improve symptoms but also reduce mortality and delay the progression of the disease.(3) Pilot programs(4) in other institutions have reduced the percentage of congestive heart failure patients re-admitted to hospitals from 20.2 per cent to 7.1 percent. Detailed changes in weight, activity levels, and shortness of breath were closely monitored enabling providers to adjust medication levels appropriately and keep patients out of the hospital. While congestive heart failure represents an attractive target, it is an elusive one at best. Case managers, armed with critical paths, have had success in other comparable institutions to Jefferson in disease categories driven by specific surgical procedures. For example, the critical paths at Jefferson have demonstrated decreased lengths of stay and improved resource utilization for such things as knee replacement surgery, and the implantation of hip prostheses. These self-limited surgical diagnoses lend themselves very well toward specific patient-centered outcome measures (the knee works or it does not) and a less variable patient population. CHF patients, on the other hand, have diverse etiologies and for many physicians, even the diagnosis of CHF is more of a clinical label rather than a defined physiologic process.

TJUH is embarking on the case management and critical path road. The first two key travelers, Rose Shaffer, RN, and Kim Jungkind, RN MPH newly appointed case managers, will find undoubtedly detours, roadblocks, and potholes. In an era where increasingly every clinical decision has an important collective economic consequence, we must hope that all of these talented persons will be successful in improving the quality of patient care through improvements in the process of that care. As always, I am interested in your views.

- David B. Nash

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