



Issues and Interventions

Effective Reporting of Case Management Outcomes

Justifying Your Department's Existence

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The Issue

Over the last decade, hospital case management (CM) departments have consistently taken on additional job functions. Hospital administrators expect case managers to increase their responsibilities, often without allocating the additional staff, as hospital systems need to cut costs. As hospital budgets tighten and profit margins continue to operate in low, single-digits-if they are positive at all-hospital CM departments are being asked to justify the staff positions in their departments.

In the past, it has been difficult to justify CM departments and positions to hospital administrators because we were lacking the protocol to measure CM's direct contribution to a hospital's bottom line. The short-term result of this lack of bottom-line contribution is that staff are cut, leaving the remaining front-line case managers even more overburdened. As will be shown with the data collected to support and justify my own CM department, both the hospital's bottom line and

quality of patient care would be greatly compromised without an efficient CM department (see Figure 1). The financial contribution of CM to the hospital's overall goals can be demonstrated (with the help of your organization's financial department) by determining your informational goals and subsequent methodologies, then consistently collecting, computing, and distributing the data. In addition to justifying your department, you will clarify your department's goals, contribute to the overall budget forecast, and identify trends that will help stabilize your hospital system's overall financial outlook.

In 1996, after initiating a new CM program across three hospitals in the Philadelphia area, my supervisor wanted justification for the number of positions in the CM department. She was feeling pressure from executive management to demonstrate CM's value through dollars and savings. Not surprisingly, there were no hard data to support our existence, much less the number of positions within the department. Because most of our savings were "soft," our contributions were conveyed through anecdotal evidence. Although we contributed significantly to the hospital's profit margin and the quality of patient care, CM jobs were in jeopardy.

My initial reaction to this situation was one of cynicism. I thought, "Let's take all the case managers out of the hospital for a period of 3 months. At the end of that timeframe the length of stay will increase, denials will be higher, chart documentation will be less substantial, patient satisfaction will decrease, and *then* we can show the dollar cost of our positions. Then everyone will truly understand what case managers do." However, the truth was that we *did* need a method to report our interventions in order to show the impact of CM on the hospital's bottom line. We worked with our financial department and developed a system that spoke to senior management and administrators with numbers (dollars), instead of anecdotes. This also provided much-needed feedback for case managers and other frontline staff. The subsequent information clarifies responsibilities to the frontline staff, shows the goals they are trying to achieve, and gives them a sense of accomplishment.

The Intervention

There are multiple questions to answer when beginning the process of reporting CM specific outcomes as the following examples demonstrate:

What Data Should Be Reported?

First, determine your department's objectives, functions, and responsibilities, and how these impact the hospital's overall goals. These data sets must align with your hospital's or healthcare system's goals in order to maximize savings.

For example, the CM department mentioned above was responsible for payor relations including denial management; percentage of denied and downgraded days referred to the physician advisor; length of stay (LOS) management including fee-for-service (FFS) Medicare; and management of physician documentation to assist

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EXECUTIVE SUMMARY FOR XXXXXX HOSPITAL Monthly Case Management Report July 21, 2003

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	YTD	GOAL
MANAGED CARE DAYS CY03	3,762	3,742	3,598	3,534	3,569	3,134							21,339	T=5.8% G=4.0%
DENIED DAYS ONLY CY03	54	57	69	53	36	60							329	
DOWNGRADED DAYS ONLY CY03 (SNF, Subacute, OBS, etc.)	55	74	102	141	56	51							479	
TOTAL DENIED DAYS CY03 (Combined denied & downgraded days)	109	131	171	184	92	111							808	
% OF CY03 DENIED DAYS ONLY	1.4%	1.5%	1.9%	1.5%	1.0%	1.9%							1.5%	
% OF CY03 DOWNGRADED DAYS ONLY	1.5%	2.0%	2.8%	4.0%	1.6%	1.6%							2.2%	
% OF CY03 TOTAL DENIED DAYS (Combined denied & downgraded days)	2.9%	3.5%	4.8%	5.5%	2.6%	3.5%							3.8%	
CY03 DOLLAR LOSS	\$ 87,900	\$ 114,500	\$ 147,300	\$ 157,000	\$ 78,800	\$ 101,700							\$ 697,200	
MANAGED CARE DAYS CY02	3,358	3,611	3,772	3,543	3,470	3,091							21,445	
DENIED DAYS ONLY CY02 (SNF, Subacute, OBS, etc.)	80	64	71	55	45	32							350	
DOWNGRADED DAYS ONLY CY02 (SNF, Subacute, OBS, etc.)	156	165	130	118	140	173							859	
% OF CY02 DENIED DAYS ONLY	2.4%	1.8%	1.9%	1.6%	1.3%	0.9%							1.6%	
% OF CY02 DOWNGRADED DAYS ONLY	4.6%	4.6%	3.4%	3.3%	4.0%	5.0%							4.1%	
TOTAL DENIED DAYS CY02 (Combined denied & downgraded days)	236	229	201	177	185	211							1,239	
% OF CY02 TOTAL DENIED DAYS (Combined denied & downgraded days)	7.0%	6.3%	5.3%	4.9%	5.3%	6.9%							5.9%	
CY02 DOLLAR LOSS	\$ 107,200	\$ 185,900	\$ 189,100	\$ 147,100	\$ 147,500	\$ 380,500							\$ 1,007,300	
NORMALIZED DOLLAR DIFFERENCE (Favorable/Unfavorable)	\$ 123,025	\$ 76,164	\$ 14,000	\$ 14,301	\$ 72,906	\$ 36,374							\$ 312,150	
CASE MANAGER CASELOAD 1:X	18	20	22	24	20	19								
CONCURRENT														
TOTAL DOLLARS RECAPTURED CY03	\$ 25,112	\$ 10,573	\$ 11,843	\$ 7,779	\$ 14,367	\$ 8,470							\$ 78,144	
PA COST CY03	\$ (6,238)	\$ (6,688)	\$ (5,963)	\$ (4,825)	\$ (4,025)	\$ (3,963)							\$ (33,702)	
RETROSPECTIVE														
TOTAL DOLLARS RECAPTURED CY03	\$ 7,600	\$ 11,300	\$ 10,300	\$ 24,500	\$ 11,400	\$ 4,200							\$ 69,300	
PA COST CY03	\$ (4,016)	\$ (5,863)	\$ (4,075)	\$ (5,575)	\$ (4,963)	\$ (1,875)							\$ (25,819)	
LENGTH OF STAY INITIATIVE														
Medicare CMI Adjusted LOS CY03	4.79	4.76	4.72	4.97	4.68	4.73								
Medicare CMI Adjusted LOS CY02	4.96	4.89	4.92	4.88	4.91	4.83								
Total Medicare DRG Cases	457	376	426	492	398	452								
DAYS SAVED	77.7	48.9	85.2	44.3	91.5	45.2								
DOLLAR SAVINGS (\$300/DAY)	\$ 23,307	\$ 14,664	\$ 25,560	\$ (13,284)	\$ 27,482	\$ 13,560							\$ 91,269	
DOCUMENTATION & COMPLIANCE INITIATIVE														
CHANGE IN MEDICAL CMI	3.90%	3.40%	3.60%	3.40%	3.80%	3.80%								
CHANGE IN SURGICAL CMI	8%	7.10%	4%	4.10%	3.10%	2.70%								
CHANGE IN SURGICAL CC'S	5.60%	7.80%	8.20%	9.10%	10.60%	9.20%								
FINANCIAL GAIN W/ EQUALIZATION	\$ 123,000	\$ 147,000	\$ 104,000	\$ 17,000	\$ 157,000	\$ 39,000								
TOTAL SAVED DOLLARS (includes normalized dollar difference, plus recaptured CY03 concurrent & retrospective dollars, plus LOS dollar savings, plus D&C financial gains)	\$ 289,788	\$ 249,300	\$ 155,665	\$ 33,294	\$ 274,449	\$ 75,816							\$ 1,078,342	
TOTAL NET DOLLARS SAVED	\$ 289,788	\$ 249,300	\$ 155,665	\$ 33,294	\$ 274,449	\$ 75,816							\$ 1,078,342	

*Credit for denial dollars normalized to 2003 T = Threshold (prior year outcome) G = Goal for current year

FIGURE 1. Sample Case Management report.

with appropriate diagnosis-related group (DRG) codification. A dollar value was assigned for CM's function of coordinating these activities by determining the financial value of each initiative to the hospital system.

What Is the Baseline and Long-Range Goal for Each Data Set?

Next, determine the goals for each data set, and establish a baseline as a tool to monitor your value as you work toward your goals. Because it is even more difficult to demonstrate savings from CM after the fact, setting a baseline at the outset of a reporting program is crucial. It is also important that the data are collected and reported consistently. Shifting methods and adjusting calculations midyear undermines your results and pollutes the analysis results.

In addition to the baseline, it is important to set *attainable* goals for improvement. Utilize a recognizable or industry-standard benchmark, if possible, or set a goal of 10% to 20% improvement over the previous year.

What Is the Financial Benefit of the Data Being Collected?

For example, the fact that 20 fewer days were denied this month, compared to the same month in the previous year, is impressive information. *But what does that mean? How does it financially impact the hospital? What is the value of CM being able to demonstrate these results?*

Whenever applicable, dollar values must be placed on each data set being tracked. In the examples above, dollar values were assigned to key indicators. Following are several additional details on how this CM department determined values and reported on its four main competencies.

Denial Management

The finance department determined a dollar value by assessing the con-

tracted rates for commercial payors and determining a blended value (including critical care, telemetry, and medical surgical rates) for a denied day (\$1100) and a downgraded day (\$400). These values were used to show the loss to the hospital from the denied/downgraded days and were compared against the same period of the prior year. The change was used to show value and then "normalized" to try to show the value if all variables were equal. Normalization is necessary because, although the percentage of days denied/downgraded is tracked in monthly, the denominator of managed care days changes, thus making the dollars reported in each month not comparable. Therefore, the change in percentage is multiplied by the current number of managed care days and multiplied by the day dollar value to create an "apples to apples" comparison and show real dollar change.

Physician Advisor Activity

A robust physician advisor (PA) program was developed across our three hospitals. Case managers contacted the PA concurrently with any denied days and these days were aggressively appealed, maximizing hospital reimbursement. The data revealed an inverse correlation between the percentage of denied days and the percent of denied days referred to the PA (i.e., the higher the percentage of denied days referred to the PA, the lower the denials). We determined that we should track two activities based on this information: *the overall percentage* and *the actual dollars recaptured*. It was also important to assess the overall expense of the PA program so that only the net was used for the overall value of CM's contribution.

Case Manager Caseloads

Variability of patient-to-case manager ratios were tracked on monthly to determine if there was

a direct correlation between the caseload ratio and outcomes in the areas of denials, LOS, and documentation and compliance impact. Over a period of time, the data supported that a higher caseload resulted in less positive outcomes in the area being tracked. We were able to increase our staffing based on this information and support our ongoing staffing component through including this information on the monthly executive summary.

Managing Length of Stay

LOS management was analyzed by tracking FFS Medicare. We partnered with finance to determine the direct cost of a Medicare hospital day, and the resulting "opportunity cost" of filling that now-empty bed with a new, paying patient. In our case, we assigned \$300 as the opportunity cost. To show the value of our FFS Medicare LOS management, we tracked the LOS by month, and benchmarked our results against the same period of the prior year. The difference was multiplied by the number of FFS Medicare admissions in the current month; that figure was multiplied by \$300 (the "opportunity cost").

Documentation and Compliance

We tracked the percentage change in both Medical and Surgical Case Mix Index (CMI), as well as the percentage change in surgical complications and comorbidities (CCs). The dollar value gained was determined separately through a methodology that was approved by finance and entered on the report to capture outcomes from the work that the case managers did on this program. At this hospital, the documentation process was added as a responsibility of the case manager instead of dedicating separate staff. While this adds to the CM workload—the information now itself supports the increased staffing.

Issues and Interventions

How Are Data Reported?

Determine the key stakeholders and the most effective method of distributing this information to them. In this hospital, an Executive Summary in a simple, color-coded, one-sheet format was sent monthly via e-mail to senior management, department heads, and all CM staff. To effectively report to this audience, it is important to show the baseline, goal, and current status on a monthly basis, along with the year-to-date data. The year-to-date data provide valuable information by monitoring trends and accounting for seasonal variations and other peaks and valleys.

Prior to distributing your initial reports, hold an orientation open to all personnel on your distribution list. This gives you the opportunity to describe the parameters that were used on the report and introduce your methodology. This will reinforce the message that the entire care team has a role in effecting hospital outcomes and in creating an

environment of quality and efficiency.

Remember that it is important to work with the finance department and senior leadership to ensure that your methodologies, formulas, and dollar values are sound. Every hospital's infrastructure and culture are unique; the method of quantifying CM's financial contribution must be modified accordingly. Start by tracking one or two key indicators then expand as your comfort level increases and the tracking time decreases. It is important to understand that data reporting will be an ongoing process that will become ingrained into the hospital's structure and expectations. It will help to create a comprehensive, sustainable alignment of all members of the healthcare team in the process of developing programs for providing quality patient care, projecting staffing needs, and maintaining financial health. Developing CM metrics will also help to clarify the job functions, goals, and responsi-

bilities of individuals and departments and serve as feedback for everyone working toward improving the quality of patient care and the bottom line.

Opportunities for improvement can be identified, and timely and new interventions implemented and easily tracked to see their positive or negative impact on the bottom line. This type of reporting not only puts a dollar amount onto the hard work of the CM staff, but also aligns the priorities of the CM department by setting goals and prioritizing the importance of those goals. Proper reporting creates a consistent, persistent approach to monitoring key data within the organization.

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