

# HEALTH STRATEGY ASSOCIATES *Smart Moves. Winning Strategies.*

## **Part 1 in the 2000 Series on Issues in the Health Care Industry**

### **An Integrated Approach to Injury Management Provider-Based Case Management**

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Most case managers today work outside the provider community, their salaries paid by insurers, TPAs, and employers. The case manager's job is to make sure the provider is doing everything possible to heal the patient, all the while ensuring the medical care rendered is as "cost efficient" as possible. While the return on this investment can often be significant, many providers are beginning to grow weary of the constant micro-management, second-guessing, and what they view as interference in their practice of medicine. While some providers are openly rebelling, others are beginning to adopt case management practices themselves.

These providers are assuming many of the functions that were traditionally performed by the case manager themselves in an effort to improve their efficiency, reduce costs, and deliver better outcomes. We will explore the forces leading this recent trend and discuss one example of a hospital system that is leading the way in provider-centered case management.

We have all heard the complaints of providers bothered by the seemingly incessant demands of the insurance company. More information, more detail, more justification for medical procedures, followed by conditional approval of part of the original treatment plan (probably at a lower negotiated price), followed by requests for even more information before additional treatment will be approved. And all this is done (in many cases) by case managers who rarely, if ever see the patient. Meanwhile, in an effort to maintain revenues in the face of discounted rates, providers are seeing more patients over a longer period of time. In fact, many providers feel they are losing control over the medical treatment they are ostensibly responsible for. While they may long for the days before utilization review and HMO capitation, those days will never return.

Before we go overboard in our sympathy for health care providers, we should remember that in large part providers brought this situation on themselves. Twenty years ago, employers faced with ever-increasing medical cost, began to force their insurers to justify their medical insurance (and Workers' Compensation) premiums. Insurers adopted cost containment programs that required justification for many expensive medical procedures. Providers, forced for the first time to justify their decisions and

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recommendations, learned how to work around the cost containment systems and programs. As the insurers (now known as “managed care organizations”) adopted new techniques to squeeze out what they perceived to be inappropriate care, providers learned how to overcome that technique, or utilized new technology, or changed coding or billing practices to thwart the MCO overseers. The result - today's ongoing, spiraling battle between “managed care” companies and providers that has brought us to the present situation.

All this maneuvering has not delivered the result that was originally sought by the employers, who, lest we forget, pay most of the bills. The maneuvering has brought increased administrative expense to the equation, to the point that employers are demanding justification from their insurers and claims payers for the administrative fees charged for health plan (as well as Workers' Compensation) management.

Employers seeking lower total costs are squeezing the margins of insurers, TPAs, and managed care companies. In addition, employers have renewed their demand for results, asking their insurers and plan administrators for ever-more specific and detailed reports showing the effectiveness of their utilization and case management services. The insurance industry, which once viewed case management as a differentiator and cost saver, is now beginning to view case management as a costly commodity. Every insurer and plan administrator has it; they all look the same, they all cost too much and deliver too little in the way of real savings or better outcomes.

The business of case management is changing as it evolves from a value-added feature to a commodity.

Finally, patients continue to feel caught in the middle between their provider and their insurer. The patient, sick or hurt, just wants to get better. Instead, the patient often feels confused by the process, concerned about complying with precert requirements and, simultaneously, fearful of alienating the provider. The added tension and stress rarely serves the patient well.

Providers are sick of what they perceive as micromanagement by clerks, employers are demanding better results and lower administrative fees, and patients are caught between the two warring parties. For many providers, the answer to this untenable problem may well lie in becoming case managers themselves. Providers cannot simply return to the practices that caused the birth of managed care many years ago, but they can recognize the forces that are driving the managed care marketplace and develop a better answer than the one offered by the market today. But, in order to win the confidence of employers and insurers, providers will have to adopt many of the same practices that they find so distasteful today.

Let's quickly examine the issues inherent in today's case and utilization management programs, and then describe a model that promises to fix some of those problems. There are two types of case management

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defined by the location where they are conducted > local, or field case management, and telephonic case management. Field case management is expensive; insurers and plan administrators have become highly skeptical of what they perceive to be suspect billing patterns and practices; communications between field staff and insurer staff are always a challenge; ensuring consistency across a large staff located in different areas has been all but impossible; field staff often do not have access to sophisticated medical and disability management information systems; and field staff productivity has often been more highly valued by the case management company than outcomes. On the positive side, field case managers are in an excellent position to facilitate transitional duty through face-to-face discussions with employers, workers, and providers; the ability to review medical records and charts and discuss them with the treating provider provides a comprehensive view of the patient; and providers may be more willing to modify their treatment plans or return to work recommendations through a personal discussion with a local clinician or counselor.

Telephonic case management is distant; often driven by protocols or guidelines that providers cannot see or gain access to; provides the case manager with an incomplete picture of the patient; and does not allow for inspection of the work site for possible transitional duty. Providers also often resent what they perceive to be interference in their medical treatment plan by a faceless bureaucrat at some insurance company. However, telephonic case management services are significantly less expensive than field-based services; deliver better communications with insurers, providers, and employers because telephonic case managers are more accessible than their field-based colleagues; facilitate the use of sophisticated medical management guidelines and protocols; and allow case managers to easily access their colleagues for help on difficult or complex cases.

Many programs are a hybrid, using telephonic case management for most cases and involving field case management only when absolutely necessary. While these programs do solve some of the problems noted above with the individual models, they are really tweaking around the edges. The fundamental problems of the process still exist > they are costly, providers resent intrusion and micro-management, patients are caught in the middle, and program results have, in most cases, been difficult to prove or report.

A promising answer to this situation lies in provider-based case management. Simply put, some health care providers are adopting a model that places case management within the medical delivery system. In effect, these providers are accepting responsibility for managing themselves, incorporating many of the same techniques that have been used by «outside' case management entities. In making this transition, providers see themselves as returning to the way they used to practice, recapturing control over their medical decisions and outcomes and regaining a measure of autonomy in the practice of

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medicine. In many ways this is true; but over the past two decades the way they practice medicine has been fundamentally altered by the managed care community. Thus, providers are in fact regaining control, but this self-control is only now possible because they are adopting many of the principles of the oft-criticized (and occasionally hated) managed care organizations.

The basic requirements for a provider-based case management approach (which we will call integrated case management or ICM) are not too different from those for any case management program. They include an ability to demonstrate results; a competitive price; and accurate and complete communications with the other parties (employer, patient, providers, and insurer/plan administrator). Although these are the basics, there are several other capabilities that significantly improve the ICM model in comparison to previous models. These include access to a complete continuum of care providers, a provider-based culture, better communications due to location within the provider organization, on-site status within the provider's offices, and a local presence. Perhaps most significantly from the insurer and employer perspective, the ICM model also has the potential to significantly reduce insurer administrative fees as the internal or vendor case management function and much of the function's direct and indirect costs are now part and parcel of the provider's services and charges. Certainly, insurers and plan administrators will not cede all control or oversight to an ICM, but present models show the vast majority of cases can be handled efficiently and appropriately within the ICM program.

Perhaps the ideal ICM model is based within a full-service health care system. The system will have a wide variety of physicians able to treat all types of cases; facilities providing 24 hour access to care; inpatient and outpatient facilities, with satellite locations throughout the service area, and most importantly a vertically integrated system of care management. This vertical integration is best understood from the patient's perspective, and for some health care systems, represents a significant diversion from their typical organizational structure.

For a musculo-skeletal injury, a vertically integrated system enables the patient to flow from the emergency room or urgent care facility to the orthopedic department, to physical therapy and rehab, and back to work. Upon admission to the system, an on-site case manager, typically a therapist, contacts the patient. The case manager tracks the patient through the health care system, ensuring appointments are scheduled on a timely basis, monitors the patient's medical and functional outcomes, and works with the other providers to modify treatment plans to reflect the patient's abilities and unique family and work situation. In addition, the case manager is in direct and frequent contact with the employer and the insurer, keeping both informed as to the patient's progress, prognosis, and estimated return to work date. In many cases the case manager visits the employment location to survey the work site, evaluate

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opportunities for transitional duty and develop a transitional plan with the supervisor, and, using the knowledge gained from the patient, help the employer develop ways to prevent the injury from occurring (or re-injury occurring). This same model can be used for patients with cardiovascular, respiratory, or other conditions.

Case managers flourish in this environment as they become part of the care delivery team, participating in treatment planning on an ongoing basis instead of coming in to intervene as an outsider. And, as active participants, case managers are able to use their expertise and experience in return to work planning to educate physicians, therapists, and other health care providers about the critical importance of the patient's functionality. Without this on-site presence, many providers would never consider the impact of their treatment decisions or the care they render on the actual functional recovery of the patient. Case managers find their role changing to that of colleague-educator, employer consultant on injury prevention and job/work site modification, and patient manager. For most case managers, the opportunity to work within an ICM system will be a chance to rediscover why they originally chose their career path.

Several health systems have adopted this model, including the Health Alliance of Cincinnati/The Christ Hospital. The results delivered by the ICM model have been remarkable; a 40% reduction in actual Workers' Compensation costs within two years of implementation of the model. The program's success has resulted in a number of employers in the hospital's service area selecting the Christ Hospital as their provider of choice for Workers' Compensation cases. In addition, in competition with several other nationally-recognized programs, the program recently received the 1997 Innovation Award from the National Managed Workers' Compensation Institute.

The promise of integrated case management for providers is more efficient operations, happier, healthier patients, and lower cost of care. And for some, a renewed control over the way they practice medicine. Insurers, employers, and plan administrators stand to benefit from lower administrative costs and lower claims costs. For those case managers fortunate to work within an ICM model, they will find the change exciting and rewarding.

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