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Shifting Strategies in Acute Care Case Management

Delivering Against Demand—Part 3

Shortages of skilled case management leaders and nurse case management professionals in an organization can result in longer lengths of stay, reimbursement denials, re-admissions and negative patient experience. *In the near term, providers will need to invest in the development of case management service delivery models that rely less on nurse case managers.* As patient care is now delivered across multiple settings, hospital-based episodes of care must be integrated in planning for both transitions of care and post-acute health care services.

Labor market realities, the impact of value-based payment models and the emergence of new care delivery models (e.g., hospital-at-home) create an imperative to reexamine how nursing care management resources are assigned and how patients are engaged in the acute care setting. Expanded use of medical social workers who are focused on resource identification, service coordination and collaborative patient engagement will be essential to alignment with care progression as managed by nurse case managers.

The pandemic has exacerbated the shortage of clinicians and ancillary service providers throughout the healthcare landscape. Although the nursing shortage has been long studied, the limited supply of qualified nurse case managers has not been as widely investigated. In response to the shortage of nurse case managers, many hospitals have outsourced utilization review functions and focused case managers on driving patient progression, identifying clinically appropriate transitions of care and managing global resource utilization.

Adverse consequences of labor shortages

Currently there are thousands of vacancies listed for case managers across the United States. Those vacancies include both front-line nurse case managers and directors. Deficits in acute care case management leadership affect case management departments and associated key performance metrics such as length of stay and medical necessity denials. Without the engagement of seasoned case management leaders, staffing retention and service delivery are often adversely affected, e.g., standards and practices associated with sequencing of care transitions may become sub-optimal, increasing the risk of readmission. A nurse case manager can be the solution to supporting a patient's receipt of care with evidence-based clinical appropriateness, collaborative formulation of patient plans of care and knowledge of healthcare system processes.

To ensure a high-performing acute care case management team, the case managers will need to have access to tools that allow them to identify key patient clinical care and treatment goals, as well as the status of required interventions necessary to ensure timely patient throughput. Situational awareness of both the clinical care goals and the available healthcare resources is necessary to drive appropriate care progression and transitions of care. Fragmentation of care management interventions that do not align the patient's post-acute needs with the available post-acute network, including additional case or disease management, may be costly.

Post–acute care is a major contributor to the costs of a hospitalization episode, as 42% of Medicare beneficiaries are discharged from hospitals to post–acute care.[1] Use of post–acute care services explained the largest portion of Medicare variation at the level of metropolitan statistical area; "differences in individual provider and hospital practices explained variation more than did regional patterns".[2] In addition, the advent of Skilled Nursing Facility (SNF)-at-Home and Hospital-at-Home creates new opportunities for the delivery of cost-effective care. The hospitals that are best positioned to support patient progression and reduce delays with post-acute care needs use collaborative service models. This allows nurse case managers to work with the interdisciplinary team, which includes social workers, to proactively identify the appropriate post-acute setting and available patient resource channels.

The advent of value-based care based on the "Triple AIM" framework developed by the Institute for Healthcare Improvement (improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care) has pressured providers to shift their focus from volume to value.[3] This payment model penalizes organizations that have delayed care progression as well as those that don't demonstrate enhanced patient outcomes.

[1] Wen Tian. An All-Payer View of Hospital Discharge to Postacute Care, 2013. HCUP Statistical Brief #205, May 2016. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp

[2] Rita F. Redberg. The Role of Post–Acute Care in Variation in the Medicare Program. JAMA Intern Med. 2015;175(6):1058. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2247158

[3] IHI. Triple Aim Initiative, Institute for Healthcare Improvement. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Bottom line:

It is vitally important to hire, develop and retain effective nursing case managers, because a lack of these key members of the interdisciplinary team will negatively impact patient progression and consistency of the patient experience. Healthcare organizations that can establish effective care progression surveillance and management approaches can reduce avoidable delays.

Key elements in shifting your case management staffing strategy:

1. Ensure employees are working to the top of their licensure: Purposeful workflow designs have both nurse case managers as well as social work case managers working at the top of their licensure.
2. Support reductions in length of stay and readmission: Clearly defined care progression management and transition of care planning can reduce length of stay and readmission risk.
3. Achieve higher efficiency and more consistency: Teams of case managers and social workers are better equipped to respond to patient needs efficiently and consistently, as they're able to utilize their core skill sets to drive care.

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