THE CENTER FOR CASE MANAGEMENT

New Definition

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Where Process Meets Practice: *The New Physician UR Advisor*

After several years of moderate inflation and stable insurance premiums, health care costs have sharply increased. At the same time, economic growth has slowed.[1] Recent headlines emphasize renewed focus by large corporations on appropriate, efficient care delivery.[2] These corporations and all levels of government have decided that the per cent of GNP spent on health care has reached its limit. For providers, reductions in reimbursement meet rising expenses at a shrinking bottom line. Academic institutions face decreased funding for graduate medical education. Two reports by the Institute of Medicine turn attention to "errors" and quality defects in the delivery system.[3,4]

With renewed external scrutiny and spreading appreciation of difficult financial choices, health systems, hospitals and their medical staffs have rediscovered the potential utility of the physician advisor. Sometimes, the VPMA occupies the role; often, a respected clinician takes the post. There have been, however, striking changes in care delivery, since the first generation advisors. In this era, the role requires new skills and carries different expectations.

Given the range of settings in which care delivery occurs are there common elements? In the academic center, where residents are key providers and rotations a fact of life one cannot assess utilization in the same manner as the community hospital. Within community hospitals there are complexities. IPAs and HMOs intervene in transition choices. Hospitalists are wild cards. If they manage a significant number of cases, they influence not only resource consumption and LOS but also the effectiveness of case management relationships. Partnerships and coverage groups show practice differences as profound as teaching hospitals. Service line organization in both settings, where patients pass from medicine to surgery and back, further complicates extracting practice patterns from data and intervening retrospectively. To affect the care process in "real time" there must be swift review and concurrent action by an interactive physician advisor. Which tools and attitudes should one bring to the updated role?

1. *First, the advisor has to be a "believer". At minimum the advisor should believe that there is a proper role for health professionals as stewards of finite resources.* One need not decide the scope and intensity of appropriate care provided an individual patient. Within the episode, however, there should be commitment to seeing the process through with a plan and with sensible dispatch. Otherwise, suffering is prolonged and ours and the patient's most precious resource, time, is not respected. In addition, efficient, systematic routine care permits the physician and organization flexibility in complex situations.

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2. Secondly, the advisor needs a political or diplomatic bent. This position is interactive. *The advisor has to be either present or accessible and willing to engage to be useful.* Chart review and suggestions to Case Managers are residuals of the old job and also part of the new. Availability only on schedule dilutes effectiveness. Solving this Thursday's problems next Tuesday costs denials and frustrates case managers. Often, the advisor encounters orneriness or outright hostility. Dealing with "the system" both within and extramurally can be opaque. If the advisor cannot spend the time, cannot accept the risk to his practice or prestige, and feels incapable or unwilling to acquire the skills and knowledge to manage people and situations, he should find another way to contribute.

3. *Fortunately, there are skills not difficult to acquire which facilitate the job. Most important is the ability to communicate. For an internal opinion leader, the "jawbone"*[5] *is the primary tool. The advisor must be clear, concise and consistent and must give the same message to all constituents.* One cannot exhort the case managers to be more assertive at the same time telling the physicians to ignore the case managers, while simultaneously assuring administration that everything is under control! In political situations, your word is your bond, so you must keep it.

4. Be persistent. An advisor may be diplomatic, but always return to the resource message. *Face to face communication does not mean "in your face" dialogue.* The advisor should consider him or herself a teacher and consultant to peers.

5. Another part of diplomacy and politics is negotiation. An extensive literature about negotiation has developed in the past two decades and the physician advisor needs familiarity with at least the basics.[6,7,8] There are several points worth reinforcing. Self knowledge or knowledge of one's own preferred style is important. Some people enjoy a rugged interchange; others like unruffled waters. Everyone has "hot buttons", which can cloud judgement and worsen situations. It is best to know your own. Next is an ability to appreciate the other person's perspective. What interest does it satisfy for that difficult internist who keeps everyone an extra day for clinical stability? How can you help her perceive that her needs and the organizations might converge? *A third key is the understanding that negotiations, especially inside a medical staff, involve long term relationships.* Retain respect for your peers. Strong-arming the orthopedic surgeon, who is a loyal supporter and frequent admitter, to save one day on a hip fracture accomplishes less than building a partnership, where a clinical pathway from preoperative office visit to rehabilitation becomes possible. *The advisor's routine presence/availability on the floor to discuss cases, when there is no pressure; helps integrate the role in the culture of the organization.* Last, one always should appreciate the possibility that discussions, exhortations, and negotiations come to naught and should have a BATNA (Best alternative to a negotiated agreement)[9]. One should never start a discussion without this forethought. (What if this guy doesn't play ball?) Knowing both parties' bottom line alternatives frames the interaction. Sometimes it's just tough.

One would not start an operation without proper instruments and one would not approach this position without knowledge of its basic tools. I would propose that physician advisors learn and demonstrate ability to incorporate algorithms, standard order sets, critical indicators, level of care criteria, and clinical pathways in practice. To integrate those helpful modalities into the care process, familiarity with the essentials of clinical "evidence" is crucial. Understanding basic statistical concepts and possessing the ability to read a paper with insight improves one as a clinician.[10] Given this advantage, the advisor should step forward when there is an opportunity to use those special skills.

Finally, the advisor must be aware that "the clinical" exists in the wider theater of the organization and the world. Clinicians have been boxed in and diminished in influence, because they refuse to look outside their immediate concerns. Within the organization, managed care contracts are important elements in days lost to denials. Finance persons without clinical backup agree to unrealistic utilization terms. Business office billing failures (wrong insurance, lack of timeliness, failure to notify within specified admission time, no pre-certification) can be wrongly attributed to the clinical side. The advisor must be cautious before accepting a clinical cause for denials. When the hospital faces reimbursement denials, the presence of a knowledgeable physician in the discussions with the HMO and other payers adds weight to the hospital side.

A physician advisor who can assist hospital administration and physicians understand, evaluate, and act on data is invaluable. Critical thinking, root-cause analysis, and other CQI techniques are core concepts for the advisor. However, the most important skill in relation to data is finding consensual meaning in the data and deriving solid action plans from data if needed. *Remember, data doesn't speak to people; people speak to people.*

In government there is a massive bureaucracy generating data, regulations, and policy. While one could go mad tracking down all acronyms and their products, the physician advisors should know where to find summaries and which mailing lists to be on. One should know the current rules. Business, senior

citizens and other powerful lobbies are at work. Knowledge of their activities rounds out the cognitive needs of the role.

For the potential or active physician advisor, there is a choice between passivity, aggression, or proactive guide. One can be seen as a pest who appears at an inopportune moment or a valued consultant to the care process. An advisor who proves respectful and firm; diplomatic and persistent; and adds unique knowledge, will grow as a significant complement to the care of patients.

About the Author

***Michael A. Parmer, MD, MPH, FACS** is a Consulting Associate. Dr. Parmer has served as a leader in clinical medicine, hospital and health system senior management and governance, academics and public policy. He practiced general surgery for 25 years in community and university faculty settings and was also the Vice President of Medical Affairs. Before joining the Center, he led a community hospital in "turnaround" as Executive VP/Administrator, and remains on its Board of Directors. His strengths are improving practice patterns, facilitating hospital/physician relationships, and enhancing operating performance. In the US and internationally, Dr. Parmer has lectured and consulted for hospitals, the HFMA, government, and public service organizations.*

References:

1 Freudenheim M, "Medical Costs Surge as Hospitals Force Insurers to Raise Premiums", *New York Times* May 25, 2001

2 Milstein A, Galvin RS, Delbanco SF, Salber P, Buck CR Jr., *Improving the Safety of Health Care: The Leapfrog Initiative*, Effective Clinical Practice 2000;6:313-316

3 Kohn LT, Corrigan J, Donaldson MS, Institute of Medicine (US) Committee on Quality of Health Care in America, *To Err is Human: Building a Safer Healthcare System*, Institute of Medicine, Washington, DC: national Academy Press; 1999

4 Committee on Quality of Health Care in America, *Crossing the Quality Chasm: a new health system for the 21st century*, Washington, DC, National Academy Press, 2001

5 Berwick D, *Sauerkraut, Sobriety, and the Spread of Change*, Institute for Healthcare Improvement, Boston MA, December 1996; p7

6 Fisher R, Ury W, Patton B, *Getting to Yes, Negotiating Agreement Without Giving In*, Second Ed., Penguin Books, NY, NY, 1991

7 Urey W, *Getting Past No, Negotiating With Difficult People*, Bantam Books, NY, NY, 1991

8 Sabenius JK, *Six Habits of Merely Effective Negotiators*, Harvard Business Review, 2001:4;87-95

9 Fisher, pp 95-106

10 Greenhalgh T, *How to Read a Paper, The Basics of Evidence Based Medicine*, BMJ Publishing group, London, UK; 2001