Clinical Resource Management

Rural facilities face unique challenges in implementing Clinical Resource Management program. Lack of experienced staff and financial constraints are two of the most common challenges, although provider support and buy-in can also be a challenge. However, rural facilities also have a smaller number of staff and providers than urban counterparts, which can be a significant advantage.

The next eight issues of Clinical connections are focused on identifying contemporary strategies to build and sustain your CRM program.


Part 2: Utilization Review and Denial Management

Part 3: Care Coordination and Discharge Planning

Part 4: Clinical Documentation Improvement

Part 5: Case Management for High Risk Individuals and Populations

Part 6: Roles and Responsibilities - Who does what?

Part 7: Managing Outcomes -

What do we Measure and When do we Measure it?

Part 8: Putting it all together - Making it Work!
Clinical Resource Management Definitions

Clinical Resource Management (CRM) has multiple definitions that can be found in the literature. The following are three definitions:

**Case Management Society of America:**
“Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.”¹

**Stefani Daniels and Marianne Ramey, Phoenix Medical Management:**
“Acute care case management is a collaborative and facilitative process of business, interpersonal, and clinical strategies that, when successfully applied, effects more efficient delivery of care, reduces variations in the consumption of clinical resources, and produces improvement in clinical and financial outcomes”.²

**The Center for Case Management:**
“Case Management is the scientific method (assess, plan, intervene, evaluate/improve) applied with individual patients and families using lateral leadership with the healthcare team to ensure clinical integration, necessary to accomplish key clinical, financial and satisfaction outcomes, as far across time and place as the patient and organization gives authority to do so. Case management is a process, a role, a system and a strategy”.³

¹ Case Management Society of America
³ Bower, K. The Center for Case Management

The Center for Case Management further identifies six distinct but overlapping functions of Case Management:

1. **Access/Liaison**
2. **Utilization Review Management / Documentation Improvement (CDI)**
3. **Care Coordination and Intervention**
4. **Discharge/Transition Planning and Execution**
5. **30-Day Post-Recovery Period**
6. **Prevention and Disease Management⁴**

⁴Karen Zander, Editor (2009, Spring/Summer). The six core functions of case management services
For our purposes, we are utilizing four key functions: Utilization Review and Denial Management; Care Coordination and Discharge Planning; Case Management; and Clinical Documentation Improvement. However, as already stated, these are overlapping and not always distinct functions.

The following paragraphs are a brief description of each function. In subsequent newsletters we will explore each of these in depth.

**Utilization Review and Denial Management**
In the hospital setting, utilization review refers to the process of determining if a patient meets medical necessity criteria and if the patient has been placed in the correct status (i.e. inpatient or outpatient). The goal is to achieve appropriate reimbursement and prevent denials from Medicare and other payors.

Denial management is another important component of utilization review. Although denials may be received by the business office, staff responsible for utilization review should be always involved for two important reasons: 1) To assist with appeals; 2) To identify denial trends and develop strategies to prevent future denials.

**Care Coordination**
Care Coordination is the process of ensuring that a patient receives care that is individualized, coordinated between disciplines and effective in meeting their care needs both in the hospital and post-discharge. Care Coordination, simply said, is coordination of care. Without an effective Care Coordination program, patients may stay too long – or - be discharged too soon – or - not receive evidence based care. The Center for Case Management has used this slogan for many years, “Plan for the Day, Plan for the Stay, Plan for the Way”. We like it!

**Case Management**
Case Management refers to the individualized management of either a group or population of patients with similar characteristics (for example Congestive Heart Failure, Chronic Obstructive Lung Disease, Diabetes) or a single individual with complex care needs. In the past few years, emergency department case managers are being used more and more frequently to manage patients who have frequent visits to the emergency department.

**Clinical Documentation Improvement**
Clinical Documentation Improvement includes both concurrent and retrospective review of provider documentation. The goal is to improve documentation and to ensure that the diagnosis and procedures are coded correctly and supported by ICD-9 codes (soon to be ICD-10 codes).
**Evaluating Your Program**

An important step in building a CRM program - is to evaluate where you are. Although we will explore each function of a CRM program in future newsletters, you may want to do a brief analysis to see what areas are your areas of strength and which may need some improvement.

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<thead>
<tr>
<th>CRITERIA</th>
<th>STRONG We Have this One Nailed</th>
<th>MODERATE We’re doing OK - but we have some work to do</th>
<th>POOR We are either not doing this - or - it's not successful</th>
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<tbody>
<tr>
<td>1. We maintain current and contemporary knowledge of regulatory standards.</td>
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<td>2. Staff and providers are educated and knowledgeable regarding medical necessity, regulatory standards and the importance of providing care that coordinated among disciplines and is evidence-based and</td>
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<td>5. Leadership is supportive of the CRM functions. When we encounter an issue, we have leadership and provider support to make the appropriate changes.</td>
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<td>6. Providers are supported with appropriate information when admission or continued stay decisions are made.</td>
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<td>7. Staff responsible for utilization review are viewed as patient advocates and a valuable resource for staff and providers.</td>
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<td>8. Staff responsible for utilization review are active partners and engaged in denial management.</td>
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<td>9. We have an effective Care Coordination program with all clinical disciplines involved. We have an effective multi-disciplinary approach that puts the patient’s needs first.</td>
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<td>10. We have a strong discharge planning program focused on making sure the patient is ready for discharge and supporting their post-discharge needs. We provide resources and support to reduce or eliminate readmissions. We have probably implemented strategies to reduce 30 day readmissions such as the RED program.</td>
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<td>11. We have identified individual high risk patients or populations and have implemented a Case Management program.</td>
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<td>12. We have a Clinical Documentation Improvement program in place.</td>
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<td>13. We collect and analyze metrics (measures) for both the process and outcomes of our CRM program.</td>
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<td>14. We have a Physician Advisor that is active and knowledgeable.</td>
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<td>15. We have a UR Committee that is active and knowledgeable</td>
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<td>16. When we encounter an issue, we have leadership and provider support to make the appropriate changes.</td>
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