Case Management Models

Best Practices for Health Systems and ACOs

Second Edition

Karen Zander, RN, MS, CMAC, FAAN

Case Management Models

Best Practices for
Health Systems and ACOs

Second Edition

Karen Zander, RN, MS, CMAC, FAAN

*HC*Pro

an *H3*.Group brand

HCPro provides information resources for the healthcare industry.

HCPro is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions.

Arrangements can be made for quantity discounts. For more information, contact:

Contents

Downloadable appendix available at

www.hcpro.com/downloads/12607.

About the Author

Karen Zander, RN, MS, CMAC, FAAN

Karen Zander, RN, MS, CMAC, FAAN, president and CEO of The Center for Case Management in Wellesley, Massachusetts, has more than 40 years of healthcare experience. In this role, she serves as a consultant and educator to hospitals, physicians, healthcare systems, and software, pharmaceutical, and consulting companies worldwide for the development of tools, roles, and systems to support provider-side control of cost and quality.

Zander previously was associated with New England Medical Center Hospitals (now Tufts Medical Center), where she served in multiple roles, including organizational development specialist in the nursing department, director of consultation for the Center for Nursing Case Management, inpatient/day hospital psychiatric service nurse leader, and staff education instructor.

Zander has been on the Partners Care at Home Patient/Family Advisory Board for three years. She has been a cellist with the New Philharmonia Orchestra in Newton, Massachusetts, for more than 20 years.

Disclosure Statement

The planners, presenters/authors, and contributors of this continuing education activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

Continuing Education

Learning Objectives

- Describe how case management professionals are accountable for deliverables

- Determine which patients and families need case/care management across the continuum

- Decipher how many social workers and RN FTEs are needed at each level of care

- Explain how to use cost-benefit analysis to identify the best model for an organization

- Discuss the various ways of classifying case management models used in health systems

- Discuss how case management functions have evolved

- Describe the precursors and rationale for health systems to establish case management services

- Identify the seven fundamental components of case management models

Contact Hours

American Nurses Credentialing Center (ANCC)

HCPro is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This educational activity for 3.9 nursing contact hours is provided by HCPro.

Commission for Case Manager Certification (CCMC)

This program has been pre-approved by the Commission for Case Manager Certification to provide continuing education credit to CCM board certified case managers. The course is approved for 8 CE contact hours.

National Association

This program is approved by the National Association of Social Workers for 3.5 continuing education contact hours.

How to obtain your continuing education certificate
In order to receive your continuing education credits, you must pass successfully pass a final exam quiz and complete an evaluation. Complete information about how to claim your continuing education credits can be found in the Instructional Guide located on the download page for this book at: **www.hcpro.com/downloads/12568.**

CHAPTER 1

Importance of Models

After reading this chapter, the participant will be able to:

- Explain the importance of models in healthcare

- Discuss the various ways of classifying case management models used in health systems

The Appeal of Models

Models are everywhere throughout our lives. As children, we might have put together plastic models of ships or experimented with models of family life when we played with dollhouses. Later in school, we learned about visual models such as vectors and societal models such as democracy. Somewhere in our experiences, we learned that models were ideas, proposals, recommendations, and—depending on the source—downright fantasy!

Models, including role models, captured our imagination, competed for our attention, and frustrated us in our attempts to copy them in everyday living. Models can either inspire or disappoint us. It is no different in the area of healthcare and in our pursuit of the best practice of case management. Some models work better in certain environments than others. Matching models to the margin and mission of a health system is the subject addressed in this book.

Using models to explain reality

Theoretical models, such as systems theory, don't automatically excite people. But they do help describe and explain a segment of reality. With astute interpretation and strategic implementation, theoretical models "trickle down" to create practice models. Practice models are combinations of

behavior (actual or ideal) and the resources and relationships that are necessary to create and sustain that behavior. Models can also be described as a representation of information, activities, relationships, and constraints. They often can be represented by diagrams and flow charts, which will be used in this book as much as possible. Another important appeal of models is the belief that they have the goal, or at least the potential, to be copied or reproduced.

As is emphasized in this book, in healthcare, it is almost impossible to completely replicate a model used in another setting. This predicament (or challenge) is due to the variation of populations served, of payer mix, and of the politics of each organization. For example, few organizations still have primary nursing, which provided patients and families greater continuity of care. Payer mix can be highly Medicare, highly managed care, or much more difficult in case management depending on the contracts.

Models in Healthcare

It is important for case management professionals to know a little of the history and important models of the professions besides their own with which they most interact. This is especially true because case management is not in itself a profession, but rather a negotiated role filled by a licensed professional in hospitals, health systems, medical homes, post-acute agencies, and the community. It is also true for hospitals that lack case management, as they will eventually find a need for that service. Each person who enters into a case management service brings his or her own profession's values but has to know and be respectful of the value of the rest of the team.

The three healthcare professions most involved in case management (nursing, social work, and physicians) have the scientific method in common, although they do not always acknowledge this. The scientific method is defined as the "principles and procedures for the systematic pursuit of knowledge involving the recognition and formulation of a problem, the collection of data through observation and experiment, and the formulation and testing of hypotheses" (Merriam-Webster, 2017).

The scientific method can be seen in the following descriptions for the professions of nursing, social work, and physicians.

Nursing

Nursing models are conceptual models, constructed of theories and concepts. Nursing models are used to create the framework through which nurses assess and plan patient care, commonly known as a care plan. Nurses have a variety of practice models that determine assignments to patients and to assistants and how to get through a shift. Nursing practice models are determined by how seriously the leadership of the staff group daily reinforces the following:

- Individual accountability for outcomes

- Continuity of a plan of care

- Continuity of care assignments day to day

However, these factors are rarely found consistently, making it both an opportunity for case management leadership as well as a huge challenge to connect with the actual caregiving staff.

Social work

Since its formal inception over a century ago, the social work profession has both created and worked collaboratively with numerous models. As society keeps shifting and learning, so does social work. Adopting the broad model of systems theory, social work applies theory and standards to its practice model.

Physicians

Physicians would claim that they are the central users of the scientific method because that is how they are trained. The history and preliminary physical is the first fact-finding tool, along with diagnostic tests. After that their model is algorithmic, with rule-ins and rule-outs as they determine therapeutics (known to nonphysicians as orders for interventions). Physicians tend to see themselves as central to this process and often do not acknowledge that nurses and social workers have their own versions of the scientific method.

Physicians have experienced more changes in their practice models than any other group, largely due to changes in the economics of healthcare and lifestyle desires of the younger members of the profession. The past 20 or so years have seen an explosion of physician practice models,

whereas physicians had, until then, worked as independent primary care physicians or specialists. Physicians formed groups to accept managed care contracts, made coverage contracts with the hospitals (such as ED and neonatal groups), or sold practices to others, including hospitals, accountable care organizations (ACO), and health systems. Whereas teaching hospitals had a tiered and well-honed medical student–intern–resident–attending infrastructure, in community hospitals, the physician coverage is often done by the local physician, primary care provider, or hospitalists. Physicians still use models, but the models have greater variety today. But problems occurred there when covering physicians waited for the patient's "real" physician to return on Monday. Over the years, more and more physician groups added physician assistants and began to accept nurse practitioners employed by their groups or by the hospital and assigned to their groups. At the same time, intensivists began to emerge as an extremely helpful new specialty service. Although this movement was slower to gain acceptance, physicians in primary care used the benefit of hospitalist coverage for their hospitalized patients.

Resulting from the practice model changes, there is more fragmentation in physician coverage than ever before. In addition, the physicians remaining in leadership positions in hospitals are expected to accomplish big projects, including quality initiatives and The Joint Commission's mandate of the formal evaluation of physicians. They are also expected to supervise physicians, including reviewing their cost per case and satisfaction scores. The world of physicians has become more complicated over the years.

Differences between jobs and practice

The ultimate difference that distinguishes service models in healthcare is whether the caregivers of a particular profession perceive themselves in a job or a practice. Working at a job implies following rules and meeting responsibilities mandated by an owner or boss. Working in a practice implies ownership of behavior that is mandated primarily by internal values within the context of expectations set by external sources. The difference between jobs and practices is not subtle, and it has enormous bearing on the way case management models are constructed and led and in the way they connect with other professional and ancillary services. This book will discuss and encourage the movement of case management models from jobs to practices and from departments to services.

The Politics of Models

Although models can appear theoretical and academic, they can be competitive, in that they compete for mindshare of a target population. More seriously, models are often the source of political struggles for access, prestige, income, and other forms of power. In a famous and life-threatening standoff with the Catholic Church, consider Galileo's assertion that the model of the universe was that the sun, not the earth, was the center of the universe. Some case managers and their administrators have felt trepidation nearly equal to Galileo's as they announce their findings that the beloved physician who has the highest amount of patients admitted is actually losing the most revenue per case, or that the skilled nursing facility (SNF) that is owned at the system level is slower than all other SNFs at accepting the hospital's referrals.

In a more moderate and modern example of implementing a new model, the Washington University Orthopedics of Barnes Jewish Hospital in St. Louis, Missouri, proudly announced its floor plan "model" for a new 60,000 square foot center "built around patient-centered care. We studied other industries to identify models for undertaking LEAN practices in healthcare" (Gelberman, 2007). A map shows the first floor with surgery suites, MRI, and therapy, while the second floor includes clinical care areas and administration. The map shows directed patient and staff flow. In addition, processes such as scheduling were refined to coordinate outpatient office visits with arthrography and MRIs. Obtaining spacious quarters in which to do one's work and better computer systems with which to schedule and communicate is every healthcare worker's dream. Patients and families usually notice the difference as well. The goal is that the model will force or create efficient workflow, positive communication, and—hopefully—good care.

In another example of a model, the mental health units at several hospitals complete their rounds by having the patients' attending physicians ask their patients how they are doing and what they need to feel better. The entire team sits and listens to the answers and then discusses next steps for each patient.

Case management models at the boardroom and executive levels of a hospital are often viewed as a necessary solution to the annoying external demands on hospitals. As such, they are viewed as an enormously expensive commodity, especially because so many of the positions are filled by nurses. One more nurse at $60,000 plus 20% benefits costs the hospital $72,000. Ten of those nurses begins to look like another physical nursing care unit, not to mention salaries for social

workers, the requested information solutions (IS) support, budgets for education, per diems to cover PTO time, etc. If the budget is higher than those in other departments, such as quality, that department starts to think of how case management can help them. If the budget is smaller than another department, such as building the new tower (which every hospital seems to be doing), case management does not receive as much attention as it needs.

In March 2017, PayScale.com estimated that the average registered nurse (RN) in Boston earned $32.35 per hour, with one in five RNs surveyed by the website indicating they did not receive health benefits. The median annual salary for Boston RNs, according to the 2017 PayScale.com data, was $66,261.

Health system environments are extremely stressed nowadays. They are not really healing environments, and graciousness is sometimes fragile. Care settings are frenetic, and the caregivers are easily distracted between the noises made by machines and people, the pieces of information flying across the nursing station, the fast turnover of patients, and the multiple (at times) computer systems they have to use. People in today's care environments across the continuum seem to want to be spoon-fed only what they must know to do an immediate task. They are in no mood for inquiry, and the conditions are not ripe for critical thinking.

Given the scenario just described, no one really wants case management in any model unless it is going to take away their work. They don't want to be reminded of regulations, they don't want their work reviewed by the case manager who feels to them like a "nosey mother-in-law," and they don't want their work slowed down, since they have their own quotas to meet. For example, one barrier to implementing case management in the ED is the fear that case managers will hold up the decision-making for too long as they review the patient for appropriate status. Implementers of new or changed case management models should be prepared to work through all of these sentiments and more.

The outstanding fact about the politics of case management is that it has survived in society for centuries! In the 19th century, its focus was social service, not healthcare. The role of case management as a process was to find shelter, food, clothing, and fuel for the needy. Policemen would have been obvious case-finders. In the 20th century, case management moved to a focus on medical necessity in acute care, following the advent of insurance companies, Medicare, and Medicaid. Finally, at the beginning of our 21st century, the service of case management has

proved itself worthy of managing a health system's or ACO's risk contracts, margin, and mission at the bedside. This model fits care management as well as all models for healthcare delivery.

The adventure continues as health systems attempt to meet the Institute for Healthcare Improvement's (IHI) Triple Aim, a framework for optimizing health system performance.

"It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions:

1. Improving the patient experience of care (including quality and satisfaction)

2. Improving the health of populations

3. Reducing the per capita cost of healthcare" (Institute for Healthcare Improvement, 2017)

The IHI website states that the Triple Aim is necessary because of how costly healthcare is in the United States. Healthcare accounts for 17% of the country's gross domestic product, and some estimate that it will account for 20% by 2020 (Institute for Healthcare Improvement, 2017).

Categorizing Case Management Models Across the Continuum

Acute care hospital models

Hospital case management has changed so much and so rapidly that it is quite difficult to categorize models and have those categories "stick" enough to be useful. A 2002 journal article by Donna Huber, a senior administrative and marketing professional with over 15 years' administrative experience, found there was "professional myopia" in owning and defining models, making the point that the evidence-based knowledge is understudied and curriculum development is difficult. Huber explored a large inventory of models and model classifiers for their "richness and diversity so that interdisciplinary communication could be facilitated by an awareness of discipline-specific definitions and models." Two hospital-oriented inventories with commentary are presented in this section.

Ideally, there should be a social worker and RN case manager during all of the prime times when patients enter EDs. There are many ways to depict prime time in the ED, including colors for days of the week. The prime ED time at many hospitals is between 10 a.m. and 4 p.m. Larger EDs tend to be overcrowded on Monday evenings with boarders.

Classification example 1: Conti

Conti (1999), who studied the broker model of case management, classified the spectrum of case management models, most of which are relevant to hospital case management, as grand, middle-range, and practice-based. They are described as follows:

- Grand models, based on systems theory, consist of core behaviors such as coordinating and integrating, which are targeted to patients, families, treatment team members, and payers. "While they are conceptually interesting, I do not believe that grand models of case management lend themselves easily to application and/or testing" (Conti, 1999).

- Middle-range models, divided into purchaser-based (such as hospitals) and provider-based, include the broker model, identified by Moxley (1989) as an indirect service strategy. Conti (1999) explains the broker model as "assessing the client's needs, identifying efficient and effective resources, advocating for the client, the payer, and the case management program, and monitoring the delivery of services."

- Practice-based models are tailored to a specific client population.

Commentary

Categorizing case management models into three groupings is simple and may be helpful. However, hospitals often incorporate aspects of all three of these proposed models, rather than selecting one. These are not mutually exclusive categories. For example, practice-based models may include integrating systems and brokering. Of the three proposed by Conti, the predominant model in hospitals is brokering—procuring resources to meet needs, especially reimbursement for admission and continuing stay, as well as options for continuing care after discharge.

Ironically, one of the barriers to leveraging hospital case management out of the strictly utilization review (UR) and discharge planning functions is the mind set of the broker model. Indirect services, such as using the chart as the prime source of information rather than the patient, can at times create poor understanding of the actual clinical situation, resulting in inaccurate case management interventions. The choice organizations have to make is to decide how central to the patient, family, and care team the frontline case management staff member are going to be.

Classification example 2: Daniels and Ramey

Acknowledging that "no definitive taxonomy has emerged," Daniels and Ramey (2005), national leaders in case management, created one useful way to begin to understand the five main models they have observed. They are paraphrased next, followed by additional commentary.

- **Clinical case management models:** "Characterized by direct patient care responsibilities," such as extension of the primary nurse role first pioneered at New England Medical Center Hospitals in Boston in 1986 (Daniels and Ramey, 2005). For example, stroke patients had the same nursing team and Critical Path/CareMap™ between the ED, the neurological intensive care unit, neurological unit, the rehabilitation unit, and the Coumadin clinic. The team met together quarterly with the attending to go over data and eventually incorporated members from other disciplines such as occupational therapy, physical therapy, pharmacy, nutrition, etc.

- **Collaborative practice models:** "Generally involve a multidisciplinary team approach using clinical pathways, variance reporting, and teaching plans to monitor and evaluate care" (Daniels and Ramey, 2005). These are also known as dyad or triad models (see Figures 1.1 and 1.2).

- **Population models:** Case managers are assigned to service lines or specific diseases, often extending beyond the hospital boundary.

- **Functional models:** Encompass both UR and discharge planning, often poorly consolidated into one department "as a means to downsize and reduce operating expenses, [and consequently] the role of the new hospital case manager position is often ill defined, the nature of the department's functions is not clearly articulated, and relationships with other disciplines are often confusing." In these models, the social workers and UR continue to work in their separate roles, without reworking relationships or filling in the gap of "clinical case management activities," or if they work in an "integrated model," the social work and UR personnel are eliminated or reduced (Daniels and Ramey, 2005).

- **Clinical resource management models:** Case managers have a collaborative relationship with attending physicians or hospitalists (and may manage the UR and discharge planning function/personnel) to "move the patient through the acute care continuum"

(Daniels and Ramey, 2005). These models include disease management models for high-risk patients and outcome models in which "clinical inquiry" and data are used.

Commentary

- **Clinical case management models:** The case management model of New England Medical Center Hospitals (NEMCH) has never been fully replicated (to the author's knowledge), due at least in part to the unfortunate nationwide slippage of primary nursing. Population health management models come the closest to the NEMCH model. In the NEMCH model, experienced primary nurses took patients with a specific diagnosis into their caseload and daily care, used case management plans and critical paths developed for that population with an attending physician, and communicated weekly with other primary nurses across the hospital and outpatient caregivers sharing the same patients to achieve specific, standardized outcomes. Outcomes were itemized under the categories of:

  1. Physiological and mental health

  2. Role and physical functioning

  3. Knowledge for self-care

  4. Absence of complications typical for that diagnostic group

Primary nurse case managers received extra training for the role, developed critical paths and outcome statements, reviewed their patients' progress throughout the hospital every week, and, with a multidisciplinary team, studied variances from critical paths and opportunities for greater efficiency. As early as 1985, NEMCH's own nurse managers were looking for the interventions that made the most difference in outcomes and length of stay. By 1986, the nurse managers supported their staff nurses' ability to take the time to be pioneers by scheduling them for key meetings and even personally covering for them to attend. More than 100 nurses (out of about 700 total RNs) participated in 27 collaborative practice/diagnostic groups during a nursing shortage! Clearly, NEMCH supported this innovation and the world began to learn of methods to give quality care with targeted outcomes while also lowering length of stay (Zander, Etheredge, & Bower, 1987).

- Collaborative practice models: All case managers and social workers would describe themselves as collaborative. However, formal, permanent teams that include case managers and social workers are few and far between in hospitals. With the exception of trauma teams, oncology teams, and other specialty groups, teams in hospitals tend to be ad hoc. Key people are used on a referral basis, rather than as part of standing teams. Although some hospitals continue to use versions of critical paths for targeted diagnoses, most were unable to continue them without better integration of the software used in the emerging electronic medical record. The loss would be understandable if there were a good alternative for a structured care methodology in software. Worse yet, truly collaborative treatment plans are rarely written by the patient's "team" or by anyone representing the team. In fact, many case managers feel fortunate to work with a clear diagnosis from the physician and are grateful to hear even a smattering of a nursing care plan from the unit nursing staff. Care planning has become a lost art of nursing.

- **Population health models:** Population models are strong and prevalent in hospitals, especially academic medical centers that have decentralized service lines, because they are clustered around physicians. However, population models often do not have a case manager who is exclusively assigned to this function or involved in data analysis, quality improvement, educational offerings, or other population-defined practices. An exception would be if the case manager were a clinical specialist or nurse practitioner who could be free to cross boundaries and would have a UR and discharge planner possibly assigned to the case manager. In this situation, the population model starts to look like the clinical resource model described in point five.

- **Functional models:** "Functional" is a good way to describe some models of acute care case management. Similar to the nursing care delivery models that divide a unit's nurses into a medication nurse, a treatment nurse, and a care delivery nurse, functional case management often splits UR from discharge planning (i.e., the triad model—see Figure 1.2). In agreement with Daniels and Ramey, functional models—whether collapsed or integrated, as they describe—are not designed or staffed to provide "clinical case management activities" (termed "care coordination" in this text), and patients and families do not get the full benefit of a clinical social worker. However, sometimes the term "integrated" is used to describe the case manager's combined responsibilities of UR, care

coordination, and discharge planning. In this definition, the care coordination function actually connects UR with discharge planning.

- **Clinical resource management models:** Clinical resource management as described by Daniels and Ramey is both a new and old contender on the hospital case management models scene. It is old in that hospitals used to have a lot of clinical resources and clerical backup to provide outcome managers and their collaborative practice groups with the information and concrete help that they needed. This is rarely the case anymore. It is new in that some hospitals are incorporating nurse practitioners as the central figure on units, and wondering whether UR and discharge planning staff should report directly to them. Indeed, nurse practitioners in some hospitals are fulfilling the care coordination function. Although nurse practitioners have enough trouble getting their own work accomplished and probably don't want case management personnel reporting to them, they desperately need the information and help that case management services provide.

CONSULTANT QUERY

QUESTION: I was asked by a large multihospital system's chief executive officer (CEO) to present a comparison study of case management models during 10 minutes of a longer meeting. What would be the best way to approach this topic in this limited time frame?

CONSULTANT RESPONSE: I was in a quandary about how to fairly describe, let alone compare, the variety of hospital and physician structures, payer mixes, internal resources and politics, and departmental staffing and skills I had assessed over 20 years! Should I compare by setting, by payer vs. provider models, by what professions served as case managers or what academic degree or certifications were required? Because I had never consulted with this health system before, I didn't know whether the CEO wanted to cut dollars and people from the department or wanted to give it more authority and tangible support.

That is when and why the "Evolving Core of Case Management Functions," described in Chapter 2, was born. It was a neutral way to describe all the possible functions within every model, and to help planners, department directors, and their executive teams determine what combination of functions must be included in their model to meet their goals. That approach seemed to work, and it served as a springboard for further discussions within the health system.

Case Management Models at the Patient/Family Level

The main dilemma for the boardroom and the frontline case management professionals is they do not warm up to "models." In fact, models are looked at with skepticism, and if they are being evaluated, models are looked at as warnings about more work to come. In addition, the broader the model, the more it is lost on the person who is supposed to work in it. The narrower or more specific the model's description is, the more difficult it is to use, and hence, the more frustrating. Looking at the patient/family level of care, every patient and family should receive the following services from case management:

1. Support of nationally published patient rights, including the right to be treated with dignity

2. Accurate, factual, and timely communication about the patient's admission to all members of the treatment team in acute care and the next level of care

3. Empathy for the patient and family story surrounding the admission, regardless of payer, socioeconomic status, or specific circumstances that precipitated the need for care

4. Advocacy for unique, individual needs

5. Coordination of timely, strategic interventions that result in outcomes that are important to the patient and, if possible and legal, the family

6. Assessment within 24 hours of admission to address demographics, risk stratification, and attribution of readmission

7. Procurement of funding and detailed arrangements for a safe, smooth, and sustained transition to the next level of care that will promote recovery, restoration, the highest level of wellness possible, or a comfortable death (i.e., provision of options to meet activities of daily living and instrumental activities of daily living)

8. Immediate access to social work services as needed or requested for skilled support during the course of the hospitalization, for family meetings, and to discuss near future healthcare decisions

9. The help of a case management liaison between the immediate healthcare team and the payer/payer regulations

10. Access to financial planning if needed or requested

11. Information about whom to contact if needed post-discharge until the patient is under the care of the accountable person at the next level of care

12. Knowledge that data collected from the patient and family will be evaluated in detail and included in trended data to improve the clinical outcomes and inpatient experience of others

Questions frontline professionals have about case management models

To the frontline professional, the case management model is really about being able to answer the following questions:

- Did everyone who was scheduled to work show up for work today, or will I have to cover for someone?

- Where will I be assigned today? Is it an easy place or group to work with?

- How many patients and/or families and/or physicians do I have on my census sheet today?

- Which patients should I get to sooner rather than later?

- Is my assignment equal to other's assignments (i.e., is it fair)?

- How many problem/pushback jobs will my assignment entail today?

- What paperwork or computer screens will have to be completed?

- How will I get through the day and out on time?

These questions will have to be answered honestly for staff members to grasp a proposed new model. Using a chart or description of how the model might look or how a case would be handled differently will help everyone's understanding. Of course, there is never one case. There are many cases, all needing something different from the case manager and/or social worker. Mostly, people want to know how their positive and problematic relationships with individuals and departments might be changed to be successful in the new model. They will want to know if there will be any more help to do the work and if there will be any education time or preceptors for new skills. They usually want the job to be easier, and they don't want to hear about any more multitasking, doing more with less, or wonderful software that will make their work more efficient. "Seeing is

believing" for staff in case management services, and the first few days of a new model with its changed behavioral expectations will set the stage for future patterns of cooperation.

For recommendations for staffing case management departments in hospitals, see Figures 1.1 and 1.2 below.

FIGURE 1.1	Dyad Model

Adult Inpatient

Care Coordination (includes UM)/Social Work

Discipline	Medical Beds	Surgical Beds	Specialty Areas	Weekend Staffing
Care Coordination Medical D/C Planning Patient Progression Readmission Avoidance Oversight of UM *CoP*s Concurrent Reviews Real Time Denial Management	1:18	1:18	1:15	1:100
Clinical Social Work Social D/C Planning/Regulatory Crisis Intervention Readmission Avoidance	1:25	1:40	1:18	1:100

Pediatric Inpatient

Discipline	Medical Beds	Surgical Beds	Specialty Areas	Weekend Staffing
Care Coordination Medical D/C Planning Patient Progression Readmission Avoidance Oversight of UM *CoP*s Concurrent Reviews Real-Time Denial Management	1:18	1:18	1:15	1:100
Clinical Social Work Social D/C Planning/Regulatory Crisis Intervention Readmission Avoidance	1:25	1:35	1:18	1:50

Source: Reprinted with permission from The Center for Case Management.

FIGURE 1.2   Triad Model

(Utilization Management/Care Coordination/Social Work)			
Rationale: UM, in the Dyad Model, utilizes 30% of total time spent			

Adult Inpatient				
Discipline	**Medical Beds** *Cardiac/ Telemetry Chronic Care Complex DRG's*	**Surgical Beds** *Ortho General*	**Specialty Areas** *ICU/imc Transplant Neuro/Trauma*	**Weekend Staffing** *Priorities*
Care Coordination Medical D/C Planning Patient Progression Readmission Avoidance	1:20-25	1:20-25	1:18	1:125-50
Utilization Management Oversight of UM *CoP*s Concurrent Reviews Real-Time Denial Management	1:45	1:50	1:45	1:125-50
Clinical Social Work Social D/C Planning/Regulatory Crisis Intervention Readmission Avoidance	1:30	1:40	1: 25	1:125-50
Pediatric Inpatient				
Discipline	**Medical Beds** *Cardiac/ Telemetry Chronic Care Complex DRG's*	**Surgical Beds** *Ortho General*	**Specialty Areas** *ICU/IMC Transplant Neuro/Trauma*	**Weekend** *Priorities*
Care Coordination Medical D/C Planning Patient Progression Readmission Avoidance	1:18-25	1:20-25	1:18	1:125-0
Utilization Management Oversight of UM *CoP*s Concurrent Review Denial Management	1:45	1:50	1:45	1:125-50
Clinical Social Work Social D/C Planning/Regulatory Crisis Intervention Readmission Avoidance	1:25	1:40	1:18	1:50-100

Source: Reprinted with permission from The Center for Case Management.

BEDSIDE BULLETIN | **Case Management Narrative: When I Made a Difference**

Introduction

Chapter 1 introduces the concept of models, highlighting the idea that models are meant to influence behavior. When social workers, nurses, administrators, and others discuss models in hospitals, they usually mean reporting relationships and the way your everyday work is organized. They also are beginning to define the expected results of all the work you do. Whatever functions you fulfill in your case management role, your service to patients, families, physicians, nursing staff, and others should have an impact. The model in which you work should support you in making that impact every day with everyone you touch. Since there is very little research as to what models make the people in them the most confident and effective, this Bedside Bulletin is designed to help you think about what you need. The best way to approach that question is to focus on when you made a difference.

Definition

A narrative is a true story that describes a situation in which you made a positive difference with a patient, family, physician, or group whom your case management care touches (Benner, 1993). It may be a short (minutes or hours) or longer period of time in which you made the difference in their clinical outcomes or overall recovery, created access to resources and reimbursement, or improved their sense of control and decision-making, knowledge, safety, etc.

Use

The most important use of this narrative is to get in touch with your work and to evaluate you at your most effective. A really good thing to do with this is to have everyone on the staff fill one out and to share them during staff meetings or a special event such as a case management week. Another use is to prepare one or more before a performance appraisal or application for a clinical ladder or promotion. You should also review your narrative with a preceptor, coach, or mentor who is available to you.

Directions

Please describe the situation in as much detail as possible, with special emphasis on what the patient, family, physician, or other person or group was like before and after you intervened, why you decided to intervene, and what exactly you did. Then, a very important step is to evaluate why you think it worked.

1. What was happening to the patient, family, physician, or group that made you decide that you needed to intervene? Describe the situation, people involved, statements made, clinical understandings, and formulations that got your attention and made you decide you needed to "do something."

BEDSIDE BULLETIN

Case Management Narrative:
When I Made a Difference (cont.)

2. What did you actually do, and how did you decide to take that action rather than 100 other possible actions?

3. What were the results of your intervention? Were there short- and/or longer-term results? Was there one specific result or several results that occurred over time?

   a) Short-term results:

   b) Downstream results (actual or projected):

4. Why do you think your intervention(s) worked? In other words, what was the "active ingredient" in the action you took? What did the patient, family, physician, or group say to you that made you know you were successful?

5. List three things that your peers on the case management and social work staff do to help you have the energy and knowledge to make a difference on a daily basis:

   a)

   b)

   c)

6. List three things that your manager and other leadership staff do or could do to help you have the energy and knowledge to make this kind of difference on a daily basis:

   a)

   b)

   c)

7. Think of one change for each question about your case management model that would help you be more:

   a) Efficient

   b) Effective in achieving results

   c) Satisfied with your role

REFERENCE:

Benner, P., Hooper-Kriakdis, P., and Stannard, D. (2011). *Clinical Wisdom and Interventions in Acute and Critical Care*, 2nd Edition. Springer Publishing Company, LLC.

Case Management Models

Best Practices for Health Systems and ACOs

Second Edition

Karen Zander, RN, MS, CMAC, FAAN

The role of case management in healthcare settings is continuously evolving to meet the needs of patients and manage the quality, financial, and legal risks health systems and accountable care organizations (ACO) face. *Case Management Models: Best Practices for Health Systems and ACOs* offers insight into how to structure case management models across the continuum of care to address these needs and risks. Definitions and rationale for fundamental models, including dyad and triad, are provided to illustrate the needed resources and recommended structure. Guidance on case management deliverables and outcomes is also included to demonstrate the value of case management.

This book explains the differences between case management and social work and the ways in which case management functions have evolved over time. Rationale for providing case management services in health systems and ACOs is also included along with suggestions for case management reporting structures. Whether your healthcare organization has an existing or developing case management department, this resource can help you select an appropriate model and seek staff with skills best suited to help you reach your goals.