CASE MANAGEMENT GUIDE TO POPULATION HEALTH
Management Across the Continuum of Care

MARY MCLAUGHLIN-DAVIS, DNP, MSN, APRN-BC, CCM

Case Management Guide to Population Health:

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About the Author

Mary McLaughlin-Davis, DNP, MSN, NEA-BC, APRN-BC, CCM, is national president for the Case Management Society of America (CMSA) and is an active member of CMSA's Public Policy Committee. Davis is a senior director of care management for the Cleveland Clinic Health System and an adjunct nursing faculty member at Ursuline College. She has provided care coordination services for inpatients, outpatients, and healthcare plans. As a clinical nurse specialist, Davis has worked extensively with patients having chronic disease, notably congestive heart failure and stroke.

Continuing Education

Learning Objectives

- Identify key stakeholders in population health

- Describe the impact of the case manager on chronic medical conditions

- Explain the importance of case management in behavioral healthcare

- Describe the primary responsibility of each interprofessional team member

- Describe how the nonlicensed case manager extender can facilitate safe transitions of care

- Identify the five social determinants of population health

- Analyze the impact of health literacy in population health

- Explain how patient preferences and choices are centric to population health

- Describe seven essential transition actions a case manager can implement to avoid unnecessary readmissions and provide a patient-centric discharge process

- Recognize the case manager's role in data capture and analytics

- Implement a process improvement strategy to include case management in a population health initiative

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Population Health: A Journey and a Destination for the Case Manager

Learning Objectives

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

- Define alternative payment models

- Describe the public health model

- Identify key stakeholders in population health

The Concept of Population Health

I was working as a new nurse for a city public health department when I was introduced to the concept of population health. At the time, it wasn't called population health but public health, focusing on chronic disease management coupled with health and wellness education. The public health nurse kept file cards on each member of the family she visited and a large file card representing the entire family. The large card might include information on grandparents, pregnant moms, teenage children, and babies if they all resided at the stated address. The work was interesting, challenging, and gratifying.

My career has taken me through many iterations of nursing and healthcare, but the population health model is in many ways reminiscent of the public health nurses' model of care. The case manager in today's healthcare system has probably heard of population health but may not understand how the move to this model will affect his or her practice.

There are several definitions of population health, but the earliest and the one most are familiar with is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003).

The reality is that the population health model cannot be successful without experienced, licensed, and often certified case managers and their direct interventions. The architects of population health can

conceptualize and design the model, but it will take the case manager with the interdisciplinary care team to actualize it. The organization must move case managers from delivering isolated services in a hospital or insurance company to the core drivers of the population health initiative across the continuum of care.

When I started in hospital case management two decades ago, our base of operation was an office next to the boiler room in the hospital basement. I learned from my colleagues across the country this was not unique. Our services were not recognized as valuable to the degree they could be. Case managers ensured all the loose ends were tied and secure; however, most health professionals realized this occurred behind the scenes. In other words, if the case manager was not on the hospital unit, the necessary care coordination did not occur. Hospital and health system leaders need to elevate this talented and knowledgeable group of professional case managers to the same level as the administrative suite— at least figuratively.

One reason for the movement to population health vs. a fee-for-service model of care is cost. The United States spends 17.1% of its gross national product on healthcare and spends 50% more of its economy on healthcare than most other countries. This cost is incurred primarily in treatment rather than in prevention and health maintenance. The high cost of technology and higher overall cost of healthcare contribute to the healthcare spending discrepancy between the U.S. and other countries (Health Care Advisory Board, 2014).

These costs may be attributed to the aging population, the complexity and chronicity of patients' health conditions, poly-pharmacy, duplicity with silo care provisions, postacute medical services (e.g., home health, durable medical equipment, skilled nursing facilities), prostheses, and implants.

Policy writers and legislators at the federal, state, and local levels cannot remedy the social conditions that affect the health of a community. This is partially due to high-risk patients, with chronic diseases using valuable dollars and resources. The ability to impact the social determents of health are affected by the high cost of treating chronic diseases, which in turn does not leave funding for necessary social services (Squires & Anderson, 2015). This dilemma places us in a circular pattern of treatment of disease, rather than prevention of disease, without overall improvement in the healthcare system.

The consumer demands lower healthcare costs and increased quality outcomes, and yet we have costs hidden throughout our system. For years, physicians have felt it necessary to order diagnostic tests and procedures, not because they would benefit the patient, but because they are concerned about a potential malpractice claim. Managed care in some form or another creates long waits for treatment, medications, and therapies. Hospital case managers, hospital and outpatient support staff, physician office staff, nurses, physician assistants, and nurse practitioners spend an inordinate amount of time attempting

to gain prior approval for payment of prescribed therapies, medications, and medical equipment. The professional case manager's time is not used efficiently, and case managers are engaged in negotiating approvals for services rather than focusing on patient care. However, if the case manager does not advocate for the patient in this manner, he or she knows the patient will not receive the necessary service.

The commercial and government payers are demanding high-quality patient outcomes, despite the fact the cost savings measures imposed by their regulations and contracts impede the financial efficiencies so necessary to the healthcare system. Collective quality coalitions such as Leapfrog set standards for low-cost, high-quality care and will not allow their members to receive care at facilities that do not meet these standards (Powell & Tahan, 2008). In addition to Leapfrog, healthcare systems and payer systems are held to standards by National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Centers for Medicare & Medicaid *Conditions of Participation* (*CoP*s), and The Joint Commission.

Legislators were concerned about the insolvency of the Medicare Hospital Insurance Trust Fund as far back as 1997 and made the decrease of Medicare spending and beneficiary benefits a priority. This piece of legislation also eliminated cost-based reimbursement for postacute services (Powell & Tahan, 2008).

This environment has set the stage for the creation and implementation of population health. However, as the details of what this model would look like emerged, it became clear that in addition to the financial benefit, patients could actually experience improved care and health. Case managers probably more than any other member of the interdisciplinary team understand how difficult it is for patients to navigate the healthcare system and understand the barriers of health illiteracy, social determents of care, chronic medical conditions, and chronic psychiatric conditions, to the treatment of disease and achievement of optimal health.

The case manager must understand the concepts involved with the population health model and how he or she will align case management practice with the goals of the model. This may not require a change in practice, as much as taking a fresh look at the shift in the healthcare paradigm and how it will assist the patient and the case manager.

The Institute of Medicine's Roundtable on Population Health Improvement incorporated Kindig and Stoddart's concept of population health as the health outcomes of a group of individuals and the distribution of the outcomes within the group (Kindig & Isham, 2014). The Institute for Health Care Improvement (IHI) developed the Triple Aim as a construct to describe a new way to deliver healthcare. Improving population health is one goal of the Triple Aim, which also include improving the experience

of care and decreasing the per capita cost of healthcare (Stiefel & Nolan, 2012). The Triple Aim also became the paradigm for the National Quality Strategy of the U.S. Department of Health and Human Services, as well as other public and private healthcare organizations, including the Centers for Medicare & Medicaid Services (CMS) (Stiefel & Nolan, 2012).

FIGURE 1.1	TRIPLE AIM
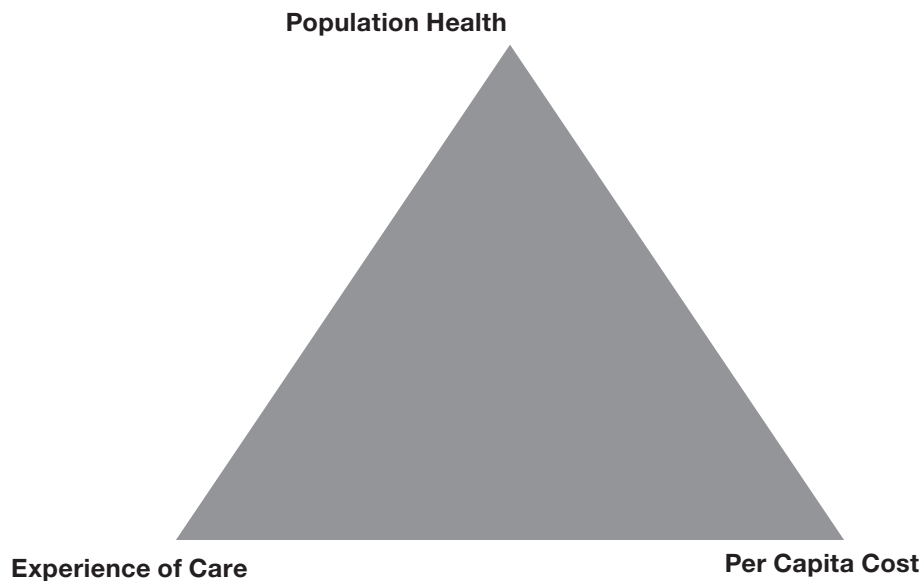
Source: Based on information from the Agency for Health Research and Quality.

The National Quality Strategy's six priorities include the following:

- "Making care safer by reducing harm caused in the delivery of care

- Ensuring that each person and family is engaged as partners in their care

- Promoting effective communication and coordination of care

- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease

- Working with communities to promote wide use of best practices to enable healthy living

- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models" (Agency for Healthcare Research and Quality, 2017)

Alternative Payment Models

The case manager understands that healthy populations are a laudable goal. He or she must also understand that population health is also a financial model. It is the merging of a healthy population concept within a payment model that is tied to quality outcomes. This is profoundly different from the pay-for-service healthcare model on which most healthcare providers base their practice.

Providers in the pay-for-service model provide care and services through the process of ordering diagnostic and treatment modalities based on the diagnosis of the patient. The third-party payer or insurance company receives the claim and pays for the treatment based on the contracted allowed amount. Providers in the population health model evaluate patients within the context of the patient's total healthcare picture and tie the diagnostic procedures, treatments, and modalities to quality outcomes. Many healthcare policymakers link population health to the concept of value-based purchasing. This is a simple concept that illustrates that the input, tests, treatments, equipment, and services produce quality health outcomes. The providers must weigh the cost of the input at every level of care and evaluate the outcomes. Practitioners must not only evaluate the cost to the patient, but also the cost to the third-party payers.

The payer may also be part of the health system that employs the provider and treats the patient. The managed care model of the 1990s used the calculation of services divided by cost, but value was not always a significant part of the equation.

Programs, services, diagnostics, and cost

Today, value is not only part of the equation, it is the key outcome measure, and it is measured by the inputs of quality and cost.

$$Value = Quality/Cost$$

Payer models

Historically, there are two payer models in the U.S.: the government payer and the commercial payer. The government payers are managed under CMS, the Department of Defense, which covers military active duty, and the Veterans Administration (VA). The VA covers all veterans who were legally

discharged from the military. The level of benefit the veteran receives is based on his or her service record and dates of service. Tri-Care is the insurance plan that covers active duty military and their dependents.

Commercial payers are contracted primarily through employers for the employees. However, individuals can and must purchase health insurance independently if not covered by their employer, or if they are unemployed; this is mandated through the Affordable Care Act of 2010.

Public health model

Healthcare providers are familiar with the public health department at the local, state, and federal levels. Bachelor of Science in Nursing students are required to participate in a nursing public health clinical rotation. The term "population health" recalls the model of a team of nurses, physicians, environmentalists, and administrators who oversee and intervene in the health of communities. The public healthcare professional assesses the community for health risks such as unsanitary conditions in homes, schools, restaurants, and water sources. The worker has the authority to close any of these facilities and to cite homeowners or condemn properties based on the laws that govern the jurisdiction in which they work.

The public healthcare provider also monitors significant chronic diseases which may be prevalent in certain communities. These include but are not limited to cardiovascular disease, asthma, infectious and communicable disease, stroke, cancer, and diabetes. These are the chronic conditions that complicate any acute care admission and reflect high costs over the course of treatment. Public healthcare providers are experts in assessing community needs, presenting chronic disease prevention interventions (e.g., children and adult vaccines, smoking cessation), and opioid addiction prevention (Petersen, Rushing, Nelson, & Rhyne, 2016). Ironically, the treatment of acutely ill children and adults is prioritized from a funding perspective over identification, prevention, and maintenance of disease. As stated earlier, the majority of healthcare dollars are spent on treating illness rather than promoting wellness. Local and state health departments keep valuable statistics related to chronic diseases and the interventions that have made an impact in mitigating them.

Rather than create additional silos, large Accountable Care Organizations (ACO) should consider partnering with the local and state health departments through formal contracts and informal collaborative partnerships. Healthcare teams from the ACOs and the health departments can make considerable progress in managing patients at home through a combined effort of disease management, expertise, and prevention. The ACO healthcare team can safely hand off patients challenged with chronic disease

to their partners in the public health department. The health department has public health programs in place with resources and knowledge to address some, if not all, of the social determinants of health.

The governess structure of public health departments are effective in impacting, advocating, improving, protecting, and promoting public health issues. The public health infrastructure is a tested model for non-acute chronic disease prevention, intervention, and evaluation of the programs they have instituted (Chauvin, Shukla, Rice, & Rispel, 2016).

Stakeholders and Customers

The patient is the key stakeholder in the population health model. This model is patient centric, with the patient plan and goals driving the activities leading to improved health of body, mind, and spirit. Other stakeholders include the patient's family or designated caregiver or partner. Populations become healthier when individuals become healthier, and improved healthcare outcomes literally occur one patient at a time.

The interdisciplinary team is also a key stakeholder, including the team in the environment where the patient is currently located as well as outside of that environment. The healthcare system, provider network, contracted payer systems, post-hospitalization services, home care, skilled nursing units, long-term care hospitals, acute rehabilitation hospitals, and the general community who rely on the healthcare service delivery model are all important customers and stakeholders.

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unit and for our stroke patients. Without a request or hesitation, the team stated that they wished to continue the project because it was the right thing to do for the patients. The team sustained the practice of measuring stroke patients' activation levels and providing stroke education tailored to the patients' activation levels.

The team not only sustained the project, they also sustained the positive outcomes. Through the duration of the pilot and the aftermath, the project yielded positive results for an evidence-based case management practice. The team witnessed the positive results of the program and was committed to continuing measuring patient's activation levels. How did this happen?

New projects must follow a set process. The case manager should be involved in the project design, analysis, and adjustments. Consider following a quality process improvement model when initiating a project. These models can often help case managers improve their practice through the population health model.

Plan, Do, Check, Act (PDCA)

Edwards Deming created Total Quality Management (TQM) in the 1950s, which is a concept familiar to many healthcare providers. Deming conducted most of his quality work in Japan after World War II. TQM gained popularity during the 1980s and 1990s when U.S. companies realized materials manufactured in Japan were of better quality and lower in price than materials manufactured in the U.S. (Rundio, Wilson, & Meloy, 2016). Healthcare providers are also familiar with the process driven by TQM, known as Plan, Do, Check, Act, or PDCA (see Figure 11.1 for more information). This is a user-friendly process and well suited for interdisciplinary teams (Zuzelo, 2010).

FIGURE 11.1	PLAN, DO, CHECK, ACT

- Define a needed change and plan with team

- Conduct a pilot project test theory with practice

Plan

Do

Act

Check

- Based on plan evaluation, create changes to original plan or begin again with new plan

- Analyze the results, meet with team, and discuss what you learned
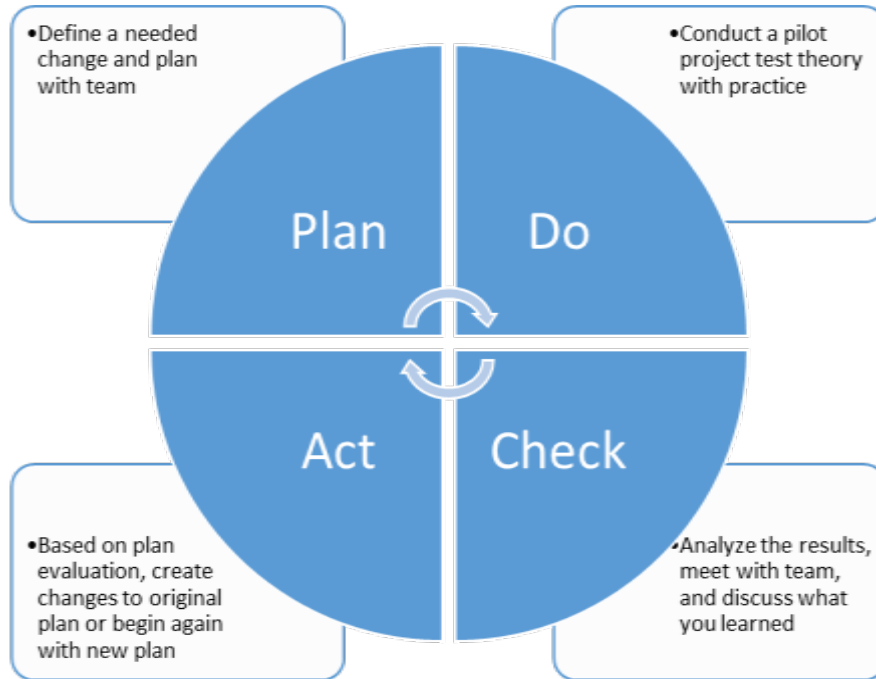
Source: Mary McLaughlin-Davis, DNP, MSN, NEA-BC, APRN-BC, CCM.

Case managers may or may not lead the interprofessional team in changing to a population health model. However, it is imperative that the case manager has a seat at the table in order for the population health model to be sustainable.

Let's take a closer look at PDCA, keeping in mind the aforementioned pilot program while examining each step:

- **Plan.** Identify a need and an opportunity. The project leader assembles a team to review the necessary change and conduct a literature review to determine best practice based on evidence. A detailed project plan is written with attention to data collection and measuring outcomes. The project manager creates a cost benefit analysis to explain the business case for the change. The team may propose changes that involve workflows but without increased costs. The project leader will organize education for the team and discuss the reason for the change and why it is necessary.

Team members have an opportunity to question and offer additional suggestions to contribute to the success of the project. The project manager and the team may have to present the project to key stakeholders prior to implementing the project.

- **Do.** Test the project; initiate a pilot. The pilot project is implemented. The project manager pays close attention to detail through the entire project to ensure all deviations from the original plan are documented. The team reports unplanned circumstances to the project manager, and these too are detailed.

- **Check.** Review the pilot; analyze what you have learned. The project manager implements the evaluation or check phase in the continuous process. He or she measures outcomes against the planned metrics and determines whether the new process or intervention was successful on the pilot scale.

- **Act.** Take action based on the project results. If it was not successful, the team reassembles and reviews the data associated with the intervention and with the outcome measures. The process continues with another planning stage. The team develops another plan or a variation of the original plan and the process. If the pilot is successful—in that it produced the outcome metrics expected—the team may report to the stakeholders and prepare to launch the project. The project manager initiates the project systemwide or includes additional units in the project, and the process will continue with the plan for the project expansion (Zuzelo, 2010).

Kaizen Process Improvement

Case managers and the interprofessional team must implement many practice changes as the population health model is implemented into the various practice settings. The team has the best chance of sustaining evidence-based positive changes using a practice improvement model.

The Kaizen Process Improvement model is similar to PDAC, but the timeline is compressed. Kaizen is a Japanese strategy for continuous process improvement. It's for everybody, every day, and everywhere. Kaizen is a scientific method, and all levels of personnel are invited to participate. The Kaizen methodology includes making changes, monitoring results, adjusting the process, and evaluating the results or short-term outcomes. A "Kaizen event" is a gathering of a group of individuals who are directly engaged in improving a process. The supervisors and directors also participate. The Kaizen event generates the beginning of the process.

The difference between Kaizen and other performance improvement methods is timing. Kaizen dictates rapid changes over a short time period. The goals are based on small changes that impact large changes. However, Kaizen is also continuous process improvement.

The 10 steps of Kaizen (see Figure 11.2) were created to keep projects on track and participants engaged in the process. The Kaizen process guides teams toward goals and implementation (Gerros & Scotto, 2009).

FIGURE 11.2 | **THE 10 STEPS OF KAIZEN**

1. **Training.** Selecting a small group of individuals to train as mentors who will also serve to select the team members.

2. **Project selection.** Make project selections based on the impact it will have for the specific area in which the project will be conducted, including any downstream effects.

3. **Team selection.** A team should be comprised of subject matter experts and anyone with pertinent knowledge of the project process.

4. **Value stream mapping.** Identification by the team; compilation of all data and specific elements needed to bring a service from inception to delivery.

5. **Process mapping.** Focuses on one specific area of the process in more detail.

6. **Developing baseline data.** Development of primary metrics to improve the process.

7. **Creating spaghetti charts.** Visual diagrams showing the information and personnel movement in the process.

8. **Conducting time study analysis.** Collecting and verifying cycle time data relative to an operation or process.

9. **Developing continuous improvement.** The team records the changes to be implemented after the collected data is analyzed and brainstorming sessions occurred.

10. **Implementing appropriate changes.** Process is implemented, and control plans in place 30–60 days after implementation for evaluation and impact of the change.

Source: Adapted from Gerros, J. & Scotto, W. (2009). Kaizen: Rapid change for a rapidly changing world. Retrieved from www.processexcellencenetwork.com/lean-six-sigma-business-transformation/articles/kaizen-rapid-change-for-a-rapidly-changing-world*.*

Visual Tools

Visual tools are also helpful for the team to picture the goal, the steps necessary to reach the goal, and the evaluation process. The logic model lays out the expected sequence of steps going from program interventions to direct outcomes. The more detailed the model, the easier it is for the participants or the evaluators to plan, execute, and evaluate a project (Rossi, Lipsey, & Freeman, 2004).

Figure 11.3 shows an example of the logic model designed for the Using Patient Activation to Transition Patients from Hospital to Home project. This project was introduced at the beginning of the chapter in the example of the stroke patient. The stroke patient's activation levels were measured, and patient education was tailored to the patient's activation level.

FIGURE 11.3 | **LOGIC MODEL PERSONALIZED STROKE EDUCATION**

Inputs			*Outcomes*		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer Term**
Identify stroke patients with the goal to return to home	Administer PAM Score PAM	Determine patient activation level	Teach to patient activation level	Teach all stroke core elements	Improved PAM No readmissions in less than 30 days for lack of knowledge about medicine or self-carel
Introduce PHR to patient and (or) care advocate	Relate patient and (or) care advocate's completion of PHR to relevance of stroke core elements	Coach patient and (or) care advocate to complete PHR	Patient and (or) care advocate complete PHR	Patient and (or) care advocate add relevant details to PHR as needed	Update PHR and take PHR to all medical and related appointments

FIGURE 11.3	LOGIC MODEL PERSONALIZED STROKE EDUCATION (CONT.)

Inputs	Activities	Outputs	Initial	Intermediate	Longer Term
The nurse teaches patients' red flags based on patient's PAM and administers PAA for each teaching encounter	Patient and (or) care advocate learn personalized red flags Improved PAA at each teaching encounter	Patient and (or) care advocate write personalized red flags	Patient and (or) care advocate link relationship between red flags and the PHR	Patient and (or) care advocate call PCP and (or) other health professional if experience red flags	High level of patient activation No readmissions in less than 30 days for lack of knowledge about medicine or self-care
Qualifying patients choose TPS	Home-going medications delivered to patient's home	Follow-up visit and (or) phone call by pharmacy liaison	Discharge medication list reconciled with home medications	Complete medication list compiled for PHR and for providers	High level of patient activation No readmissions in less than 30 days for lack of knowledge about medicine or self-care
Patient and/ or care advocate complete Press Ganey Patient Satisfaction Survey					Discharged stroke patients experience higher patient satisfaction scores No readmissions in less than 30 days for lack of knowledge about medicine

Note: **PAM = Patient Activation Measure, PHR = Personalized Health Record, TPS = Transitional Pharmacy Service, PAA = Patient Activation Assessment**

Source: Mary McLaughlin-Davis, DNP, MSN, NEA-BC, APRN-BC, CCM.

Standards of Practice

The case manager leader in the population health model must emphasize the necessity of every case management plan. Whether it is an individualized plan of care or change in case management practice, it must be grounded in an evidence-based plan. The CMSA Standards of Practice (SOP), reviewed in depth in an earlier chapter, provide guidance on this in both the Outcomes Standard and the Professional Responsibilities and Scholarship Standard. These two standards reinforce the necessity of grounding your agency or institution case management policies in evidence with demonstrated outcomes and metrics.

Outcomes

The case manager conducts a thorough assessment of the patient. While documenting the patient's medical, cognitive, behavioral, and social needs, the case manager also documents the patient's strengths, engagement with the case manager and the healthcare team, and willingness to participate in a healthcare plan.

The standard is demonstrated for case managers in the following ways:

- Documented knowledge of the clinical aspects of the patient population and application of evidence-based interventions in the plan of care.

- The case manager monitors the health system or health plan's quality performance measures to evaluate where and when practice improvement is necessary. The case manager may use patient and family satisfaction surveys to evaluate the effectiveness of the case management plan.

- The case manager will become familiar with the regulatory and compliance mandates governing the case management practice site, such as the health system or any other environment where the case manager practices.

Standard Professional Responsibilities and Scholarship

The professional case manager should instill a level of professionalism and scholarship in his or her case management practice. The case manager is a leader in the population health model and it is incumbent on him or her to maintain current knowledge of case management best practice. The case manager must also pursue new evidence-based knowledge and disseminate the knowledge to his or her patients,

colleagues, and the community. The case manager must maintain current with all competencies required and necessary for a level of excellence in case management practice.

The case manager demonstrates a level of excellence in case management by:

- Integrating evidence-based case management into practice. The case manager is able to verbalize the rationale for policies and guidelines and promote them within the work environment.

- Awareness of new research, process improvement projects that demonstrate positive patient outcomes and new efficiencies in practice.

- Pursuing case management certification through an evidence-based examination. Pursuing higher education and joining a professional case management organization.

- Dissemination, through publication and or presentations in the work place, local and national conferences, professional journal authorship, and newsletters (CMSA, 2016).

Dissemination and Sustainability

The case manager leader and his or her team create a case management system that will enhance a population health model. The teams that are affected by the changes from the fee-for-service environment to the value-based population health model will not understand it, accept it, or promote it without fully understanding why the change is necessary, how it will benefit patients, and how it will benefit the other team members. The case manager leader cannot explain The Triple Aim, value-based purchasing, and population health just once and expect it will be accepted or followed. The benefits must be continually reinforced.

The case manager must pay as much attention, time, and effort into the presentation of new evidence-based interventions as he or she devoted to the development, intervention, and evaluation of the intervention to ensure the adaptability and sustainability of the desired project. The project manager can use the PAPEL Model (see Figure 11.4) to have the best effect on his audience and for making the case management argument for the needed change.

Case managers are typically confident and comfortable in presenting material in both formal and informal settings. Case managers are often persuasive. However, the need for meticulous presentation skills and practice, practice, practice, cannot be overemphasized. The case manager will need to memorize the "elevator speech" regarding the project and be prepared to deliver it at a moment's notice.

FIGURE 11.4 | **THE PAPEL MODEL EXPLAINED**

The case manager uses the PAPEL Model presentation in any format, including oral, written, technical, and web based.

- **P** represents **Purpose** and simply implies the stated reason or objective for your presentation and what you hope to accomplish.

- **A** represents **Audience** and is both who the case manager hopes to reach and those who are actually exposed to the presentation.

- **P** is **Presentation** and indicates the mode of the presentation, oral or written, with or without audiovisual equipment formal (planned presentation), informal (elevator speech), or panel presentation.

- **E** is **Evidence** and represents the content of the presentation, including anecdotes, opinion, and data.

- **L** is **Language** includes diction, formality or informality, scientific, or community talk.

Source: Adapted from Harris, J. L., & Roussel, L. (2011). From project planning to program management. In J. Harris, L. Roussel, S. E. Walters, & C. Dearman, Project Planning and Management: A Guide for CNLs, DNPs, and Nurse Executives, 1–18.

The case manager needs to understand how influential costs are to the sustainability of a project. The Population Health Model is operating in a completely different reimbursement model than the one to which chief operating officers are accustomed. Many case managers and other disciplines are asked to provide a new way of operating that is budget neutral. Case managers are familiar with this directive, as healthcare costs and finances are a familiar topic.

Despite the familiarity with healthcare finances, the case manager will want to conduct a cost benefit analysis both before the project with anticipated costs, including labor and equipment, and after the intervention, comparing the estimate or budgeted costs with the actual costs. The case manager should present the cost and benefit in terms of actual dollars. Cost-effectiveness is presented in terms of natural units or outcomes such as readmissions, blood pressures, length of stay, and HgbA1c. Cost utility is measured as both length and quality of life. The case manager's application of lean theory, adding value, while removing waste, increasing flow and variability, and enhancing sustainability, is highly desirable (Harris & Roussel, 2011).

The case manager will tailor the message to fit the audience in both style (formal or informal) and dress (business suit or work attire). The case manager should also determine whether to deliver a data-driven

message or use a storytelling approach. We understand that patients direct a population health model. Patients are at the heart of our success, and we desire to have them participate as willing partners, engaged and activated. The case manager might present the innovation to the population health model systems board of directors and then present the same innovation to a community forum. Obviously, he or she will tailor the message to the two different but equally important audiences.

The case manager has a unique and comprehensive skill set, consisting of the following:

- Good communication

- Strong negotiation

- Contract comprehension

- Knowledge of community resources

- Networking abilities

- Navigate various systems

- Benefits knowledge

- Medical knowledge

- Presentation skills

- Care coordination

- Strong clinical knowledge (Fraser, 2017)

Case management is the linchpin for successful care coordination within a population health model. The case manager is an essential member of the population health team. This is the pivotal time for case managers to demonstrate the ability to integrate case management services across the continuum of care for all patients.

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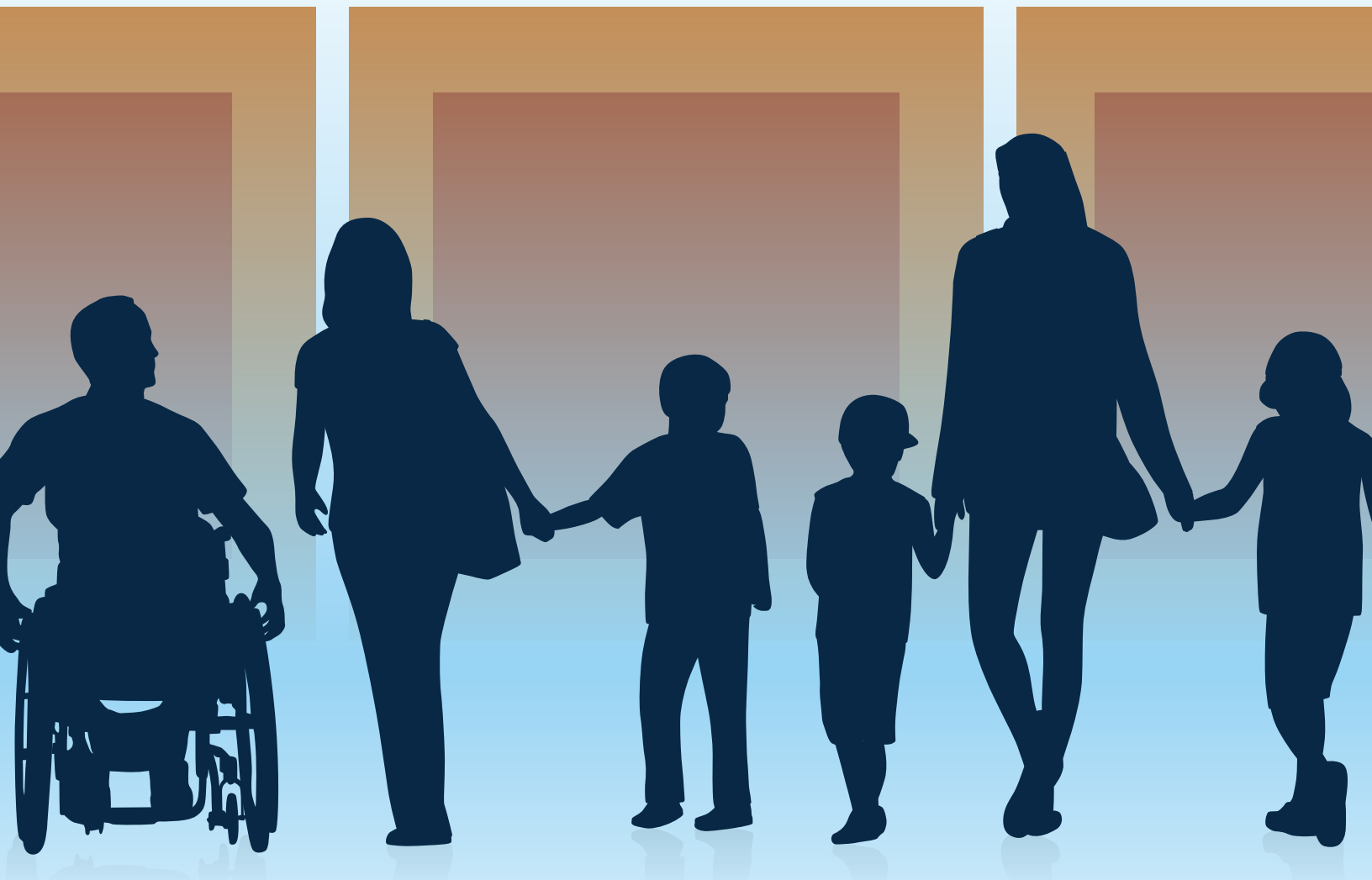Zuzelo, P. R. (2010). The clinical nurse specialist handbook. Jones & Bartlett Publishers.

CASE MANAGEMENT GUIDE TO POPULATION HEALTH
Management Across the Continuum of Care

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Dramatic changes are occurring in healthcare as pay-for-quality and performance improvement continue to drive innovations in care delivery. One of the changes that is fast becoming a critical outcomes driver for provider organizations is population health management. While this new model has been demonstrably effective at achieving better patient outcomes at a lower cost, case managers need resources and guidance on how to approach an overhaul to their program.

Case Management Guide to Population Health: Management Across the Continuum of Care is a comprehensive playbook for ensuring the effectiveness of a population health program. This resource is designed to help case management and other healthcare professionals examine social determinants of population health, gauge the sustainability of population health modules in case management, and measure case management outcomes.