



Hospital Case Management Models

Evidence for Connecting
the Boardroom to the Bedside



Karen Zander, RN, MS, CMAC, FAAN



THE CENTER FOR CASE MANAGEMENT

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Contents

| | |
|---|------|
| About the Author | vii |
| How to Use the Tools on the CD-ROM | viii |
| | |
| Chapter 1: Importance of Models | 1 |
| The Appeal of Models | 1 |
| Models in Healthcare | 2 |
| The Politics of Models..... | 4 |
| Categorizing Hospital Case Management Models | 6 |
| Case Management Models at the Bedside..... | 11 |
| Bedside Bulletin: Case Management Narrative: When I Made a Difference | 12 |
| | |
| Chapter 2: Case Management Practice in Hospitals: Coming of Age | 15 |
| Defining Case Management and its Inherent Authority | 15 |
| Models Should Establish the Expert Authority of RNs and Social Workers..... | 19 |
| Background: Drivers and Rationale for Hospital Case Management | 21 |
| The Evolving Core of Case Management Functions..... | 23 |
| Bedside Bulletin: Think Like a Shark, Act Like an Octopus | 26 |
| | |
| Chapter 3: Case Management’s Position in the Organization | 31 |
| Case Management as the Hospital’s Engine | 31 |
| Scalar Process: To Whom Does the Case Management Department Report? | 32 |
| Bedside Bulletin: Your Network from Bedside to Boardroom..... | 38 |
| | |
| Chapter 4: Fundamental Components of Hospital Case Management Models | 43 |
| Components of Case Management Models..... | 43 |
| 1. Role of the Director or Manager..... | 44 |
| 2. CMS’ Conditions of Participation and The Joint Commission | |
| Requirements for a Hospital Plan | 46 |
| 3. Utilization Review/Case Management Committee | 47 |
| 4. Typical Department Structures and Personnel | 50 |
| 5. The Physician Advisor/Medical Director of Case Management..... | 52 |
| 6. Case Management Standards for Hospitals | 54 |
| 7. “Philosophy” of the Case Management Service Matters | 55 |
| Bedside Bulletin: Care Coordination Rounds..... | 61 |

| | |
|---|------------|
| Chapter 5: Hospital Case Management Deliverables | 69 |
| The Meaning and Importance of “Deliverables” to a Board..... | 69 |
| Data Dashboards: “Vital Signs” on Display..... | 72 |
| Determining Accountability for Deliverables on the Data Dashboard..... | 73 |
| Interpreting the Data Dashboard | 81 |
| Presenting the Case Management Data Dashboard | 84 |
| Holding Case Management Professionals Accountable for Deliverables | 86 |
| Bedside Bulletin: Complex Care Rounds | 88 |
| | |
| Chapter 6: Matching Models to Deliverables | 93 |
| Deliverables from the Board to the Bedside | 93 |
| Combination of Approaches and Model Shifts to Achieve Deliverables | 98 |
| Case Example 1: Before and After Results of Converting a Model | 100 |
| Case Example 2: Transitioning from a Social Work to Social Work/RN Case Manager Model | 103 |
| Cost-Benefit Analysis: Finding an Effective and Sustainable Model..... | 105 |
| Bedside Bulletin: Role Clarification..... | 110 |
| | |
| Chapter 7: Using the Evidence-Based Practice (EBP) Method for Case Management Model-Building | 117 |
| Emerging Patterns of Effective, Sustainable Models..... | 117 |
| Eight Key Model-Building Questions Incorporating EBP | 118 |
| Number 1: The Flat vs. Hierarchical Department Question | 119 |
| Number 2: Which Patients and Families Need Case Management Services—Caseload vs. Workload?..... | 121 |
| Number 3: The Scheduling/Cross-Coverage Question | 124 |
| Number 4: How Many FTEs are Necessary to Cover Caseload Numbers and Meet Targets? | 128 |
| Number 5: What is the Most Effective Assignment/Deployment Method? | 133 |
| Number 6: What Case Management Function Is the Most Important for Achieving All the Deliverables Expected? | 138 |
| Number 7: The Social Worker–RN in the Case Manager Role Question | 143 |
| Number 8: The Efficiency Question | 145 |
| Bedside Bulletin: Time Management | 147 |

Chapter 8: Unique Hospital Case Management Models and Division of Responsibility 153

- Case Management Services and Nursing..... 153
- Role Strain Between Nurse Case Managers and Nursing 154
- Concept of Most Vulnerable Unit (MVU)..... 156
- Advanced Practice Nurses: Clinical Specialists, Nurse Practitioners, and Clinical Nurse Leaders 157
- The American Nurses Credentialing Center (ANCC) Magnet Recognition Program® and Case Management..... 160
- Emergency Department Case Management Models..... 161
- The Insider-Expert Model for At-Risk Populations and Disease Management 165
- Connecting the Acute Care Model to Community Postacute Networks..... 167
- Case Management Models for Specialty Hospitals..... 167
- Bedside Bulletin: Reframing and Other Helpful Approaches to Conflict 174

Chapter 9: Morphing Models for Future Demands 179

- Health System Case Management Models..... 179
- The Future of Physicians in Hospitals..... 182
- The Future of Case Management Functions in “The Evolving Core” 184
- The Evolution of Board Governance 187
- Is There a Perfect Model? 188
- Finding Your Perfect Model 189
- Bedside Bulletin: How to Run a Healthcare Team Meeting..... 193

Continuing Education Instructional Guide197

- Target Audience 197
- Statement of Need..... 197
- Educational Objectives..... 197
- Faculty 199
- Accreditation/Designation Statement 199
- Commission for Case Management Certification (CCMC)..... 199
- Disclosure Statements 199
- Instructions 199

Continuing Education Exam.....201

Continuing Education Evaluation 207

Dedication

Writing this book was a joy in the midst of challenge, and in a space and time made possible by my husband, Bernhard Metzger. He has always been “the wind beneath my wings,” for which I thank him once again.

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About the Author

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Karen Zander, RN, MS, CMAC, FAAN, is principal and co-owner, with Kathleen Bower, of The Center for Case Management, Inc. Their pioneering work with clinical case management and CareMap® systems, begun at New England Medical Center Hospitals in Boston, is internationally recognized. Hospitals & Health Networks has named her a Cutting Edge leader. Zander is the editor of *The New Definition* newsletter and coauthor of *Emergency Department Case Management: Strategies for Creating and Sustaining a Successful Program*, published by HCPro, Inc. She is a member of the credentialing board for the Case Management Administrative Certification exam. She has two grown daughters and lives with her husband, 98-year-old mother, and 14-year-old dog.

How to Use the Tools on the CD-ROM

Benefits of Hospital Case Management Models: Evidence for Connecting the Boardroom to the Bedside

Many of the book's tools and templates can be found on the accompanying CD-ROM, along with bonus example tools. Put your organization's name on the forms, customize them to fit your needs, and print them out for immediate staff use.

How to Use the Files on Your CD-ROM

To adapt any of the files to your own facility, simply follow the instructions below to open the CD. If you have trouble reading the forms, click on "View," and then "Normal." To adapt the forms, save them first to your own hard drive or disk (by clicking "File," then "Save as," and changing the system to your own). Then change the information to fit your facility, and add or delete any items that you wish to change.

The following file names on the CD-ROM correspond with tools listed in the book:

| File name | Document |
|-----------|---|
| Fig 2-3 | Figure 2.3: Relationships of Role to Function to Model |
| Fig 3-2 | Figure 3.2: Pros and Cons of Case Management Director Reporting Structure |
| Fig 3-3 | Figure 3.3: Pros and Cons for New Case Management Director Reporting Structures |
| Fig 3-4 | Figure 3.4: Case Management, Inc. |
| Fig 5-1 | Figure 5.1: Case Management Influence on Outcomes from Board's Data Dashboard |
| Fig 5-2 | Figure 5.2: Sample Display of Relationship of Payers, CMI, and LOS |
| Fig 5-3 | Figure 5.3: Sample Data Inventory |
| Fig 5-4 | Figure 5.4: Dashboard Sample Exercise |
| Fig 5-5 | Figure 5.5: Progress Over Time of FTEs Added for Clinical Documentation Improvement |
| Fig 6-6 | Figure 6.6: The Scope of LOS and Hanging Fruit |
| Fig 6-10 | Figure 6.10: Cost - Reimbursement = Loss Per DRG |

| | |
|----------|---|
| Fig 6-11 | Figure 6.11: ROI of Additional CM Personnel |
| Fig 6-12 | Figure 6.12: Relationship of Case Management Functions to Organizational Goals (deliverables) |
| Fig 6-13 | Figure 6.13: Roles of Unit-Based Care Management Team |
| Fig 7-1 | Figure 7.1: Options for Dividing 28 Patients Between RN and SW |
| Fig 7-2 | Figure 7.2: Case Management Department Personnel FTEs by CMI |
| Fig 8-1 | Figure 8.1: Roles of Case Management Services in Acute Care and Rehabilitation |

The following files are bonus examples found only on the CD-ROM. They are organized by the chapter to which the material relates:

| File name | Document |
|------------------|---|
| Chapter 2 | |
| Brochure | Case management brochure |
| ImpMessage | Article from <i>New Definition</i> – “It’s Not the ‘Notice,’ It’s the Message’ that Matters: Addressing Patients’ Rights to be Informed of Discharge and Rights to Appeal” by Jackie Birmingham, RN, MS, CMAC |
| Chapter 3 | |
| PtsFamilies | Article from <i>New Definition</i> – “Looking Under the Sheets: The Case Manager’s Practice of Direct Contact with Patients and Families” by Karen Zander, RN, MS, CMAC, FAAN. |
| Chapter 4 | |
| Vision | How case management will look (the vision/message) |
| UR-CM | UR-CM algorithm |
| UR-SW | UR-SW algorithm of integrated partners |
| PAJob | Physician advisor job description |
| CMJob | Director of case management job description |
| UR-UMPlan | UR-UM plan from a hospital |
| PA-URAdvis | Article from <i>New Definition</i> – “Where Process Meets Practice: The New Physician UR Advisor” by Michael A. Parmer, MD, MPH, FACS. |

Chapter 5

| | |
|-----------|---|
| Dashboard | Data dashboard template |
| Results | Case management report of results |
| DataMap | Article from <i>New Definition</i> – “DataMap™: A Dashboard to Guide the Executive Team” by Karen Zander, Principal & Coowner and Maria Hill, RN, MS, Senior Consultant of CCM. |

Chapter 6

| | |
|-----------|--|
| CareGraph | Article from <i>New Definition</i> – “CareGraph™ Clinical Progressions: First Substantive Breakthrough Since Clinical Paths” |
|-----------|--|

Chapter 7

| | |
|--------------|---|
| Flat | Diagram of a flat department structure |
| Hierarchical | Diagram of a hierarchical department structure |
| Referral | Diagram of a referral method |
| Unit | Diagram of unit-based staffing distribution and cross-coverage partners |
| Service | Diagram of service line assignments |
| Agreement | Example of service agreement between the case management department and the patient care units and physicians |
| Funnel | Funneling exercise for CM-SW partners |
| Seven | Seven important tasks of case management |
| SWPlan | Daily plan for social work |

Chapter 8

| | |
|----------|--|
| MVU | Article from <i>New Definition</i> – “The Most Vulnerable Unit: Crisis on the Horizon” by Kathleen A. Bower, DNSc, RN, FAAN |
| CommCM | Article from <i>New Definition</i> – “Community Case Management: A Caring Blend of Heart, Art, and Science” by Deborah Anderson, MSW |
| 10 Steps | Ten steps for developing a post-acute network (PAC) |

Chapter 9

| | |
|-----|---|
| POC | Article from <i>New Definition</i> – “Programs of Care: Governing Clinical Practice Across Time and Place” by Tina Davis, RN, CMAC, MS, CNS |
|-----|---|

Installation Instructions

This product was designed for the Windows operating system and includes Word files that will run under Windows 95/98 or greater. The CD will work on all PCs and most Macintosh systems. To run the files on the CD-ROM, take the following steps:

1. Insert the CD into your CD-ROM drive.
2. Double-click on the "My Computer" icon, then double-click on the CD drive icon.
3. Double-click on the files you wish to open.
4. Adapt the files by moving the cursor over the areas you wish to change, highlighting them, and typing in the new information using Microsoft Word.
5. To save a file to your facility's system, click on "File" and then click on "Save As." Select the location where you wish to save the file and then click on "Save."
6. To print a document, click on "File" and then click on "Print."

Chapter 1



Importance of Models

Learning objectives

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 hospitals

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 hospital 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. One definition is that models are a representation of information, activities, relationships, and constraints (ICH/Architecture Resource Center 2007). 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. This aspect of replication is included in another definition of model: "A representation of a set of components of a process, system, or subject area, generally developed for understanding, analysis, improvement, and/or replacement of the process" (ICH/Architecture Resource Center 2007).

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.

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. Each person who enters into it brings his or her own profession's values, but has to know and be respectful of the values of the rest of the team.

The three healthcare professions most involved in case management 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's Online Dictionary 2008).

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

Hospital Case Management Models

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 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 non-physicians 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 version 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. Whereas teaching hospitals had a tiered and well-honed medical student–intern–resident–attending infrastructure, in community hospitals the physician coverage was flatter. 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 in 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.

As a result of these main practice model changes, there is much 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 (formerly JCAHO) newest mandate of the formal evaluation of physicians (The Joint Commission 2008).

Differences between jobs and practice

The ultimate difference between 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 classic 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, MO, proudly announced its floor plan "model" for the new 60,000 square foot center "built around patient-centered care. We studied other industries to identify models for undertaking LEAN practices in healthcare"

Hospital Case Management Models

(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.

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 geographic nursing care unit, not to mention salaries for social workers, the requested 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.

Hospital 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 acute care environments want to be spoon-fed only what they have to 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 more than three 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 hospital's margin and mission at the bedside. Now the adventure continues.

Categorizing Hospital Case Management 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. Huber found there was "professional myopia" (Huber 2002) in owning and defining models, making the point that the knowledge evidence base is understudied and curriculum development is difficult. She 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.

Classification example 1: Conti

Conti (1999) 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, iden-

tifying 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 ones 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 select 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 mindset 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. (See the accompanying CD-ROM for the article “Looking Under the Sheets.”)

Classification example 2: Daniels and Ramey

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

1. **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).
2. **Collaborative practice models:** “Generally involve a multidisciplinary team approach using clinical pathways, variance reporting, and teaching plans to monitor and evaluate care.” Also known as dyad or triad models.
3. **Population models:** Case managers are assigned to service lines or specific diseases, often extending beyond the hospital boundary.
4. **Functional models:** Encompass both utilization review and discharge planning, often poorly consolidated into one department “as a means to downsize and reduce operat-

ing expenses, [and consequently] the role of the new HCM (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 the utilization reviewers 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.

5. **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." These models include disease management models for high-risk patients, and outcome models in which "clinical inquiry" and data are used.

Commentary

1. Clinical case management models: To our knowledge, the model of New England Medical Center Hospitals (NEMCH) has never been fully replicated, due at least in part to the unfortunate slippage of primary nursing nationwide. 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 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, and 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 (LOS) (Zander, Etheredge, & Bower 1987).

2. **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, but that remains to be seen at the time of this writing. 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.
3. **Population 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.
4. **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 utilization review from discharge planning. 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.

5. **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

Q **Question:** I was asked by a large multihospital system's CEO to present a comparison study of case management models during 10 minutes of a longer meeting.

A **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 served as a springboard for further discussions within the health system.

Case Management Models at the Bedside

The main dilemma for the boardroom and the director is that frontline case management professionals 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 less realistic it is to the frontline staff member, and hence, the more frustrating.

To the frontline professional, the case management model is really about:

- 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?
- Is my assignment equal to other’s assignments?
- How many problem jobs will that 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 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.

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 caring 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, 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

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

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.”
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

References

- Benner, P. (1993). Clinical narrative accounts that illustrate nursing practice. Available at www.bennerassociates.com.
- Conti, R.M. (1999). "The broker model of case management." In Cohen, E., and De Back, V. (Eds.) *The Outcomes Mandate: Case Management in Health Care Today*. St. Louis, Mosby.
- Daniels, S., and Ramey, M. (2005) *The Leader's Guide to Hospital Case Management*. Sudbury, MA: Bartlett and Jones.
- Huber, D. (2002). The diversity of case management models. *Lippincott's Case Management* 7 (6): 212-219.
- ICH Architecture Resource Center. (2007). Treasury Enterprise Architecture Framework. Interoperability Clearinghouse Glossary of Terms. Available at www.ichnet.org/glossary.htm.
- Moore, G., and Wasson, J. (2007). "The ideal medical practice model: Improving efficiency, quality and the doctor-patient relationship." *Family Practice Management* 14 (8): 20-24.
- Sobel, D. (2000). *Galileo's Daughter: A Historical Memoir of Science, Faith, and Love*. New York: Penguin.
- Gelberman, R. "Washington University Orthopedics takes lesson from Taiichi Ohno." Available at http://news-info.wustl.edu/pdf/ortho_poster.pdf.
- Moxley, D.P. (1989). *The Practice of Case Management*. Human Services Guide #58. Thousand Oaks, CA: Sage.
- Zander, K., Etheredge, M.L., and Bower, K. (1987). *Nursing Case Management: Blueprints for Transformation*. Boston: New England Medical Center Hospitals.