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THE CENTER FOR CASE MANAGEMENT

New Definition

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Looking Under the Sheets: The Case Manager's Practice of Direct Contact with Patients and Families

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Introduction

Although case management is steadily becoming a serious discipline[i], there are several aspects of the practice that continue to create inconsistencies, confusion, and vulnerabilities for case managers and their patients. Most problematic is the lack of expectation that case managers should actually have direct contact with their patients. Direct contact with patients, in person or (depending on role) over the phone, should be as fundamental to case management as taking vital signs is to a staff nurse or a history and physical is to a physician. Patient contact provides accuracy, credibility, and a platform for a relationship. If there are no clinical social workers in the organization, then family contact is also essential to the case manager's role.

The expectation to symbolically "look under the sheets" **does not** seem to depend on the nature of the case manager's role: CCM has seen an absence of patient contact regardless of whether the case manager is working in a Utilization Review role, an integrated UR and Discharge Planning role, or other combinations of function and assignment. CCM proposes that the difference in practice lies in the general expectation set by the case management administrator, in combination with the individual case manager's definition of "practice," i.e. *specifically using oneself as an instrument of assessment, relationship, and change*. Even in the most narrow of case manager roles, patient contact provides information as a source for future decisions and advocacy when needed. In the most advanced roles, the case manager is an "insider-expert", using the relationship with patients and families to help them select and practice new behaviors.[ii]

In the clinical arena, contact minimally includes greeting and viewing patients; more extensive contact includes formally assessing patients, talking with patients about their wants and needs for the admission and beyond, attending family meetings if held, and any other reason to directly interact with the patient. Few case managers would refuse to see patients if requested. Most case managers report that they will see patients if necessary, but that it is *not* a standard in every day practice. They typically rely on screening referrals and information from other clinicians. They have often found more reasons to not see patients than to see them, as in the examples below:

Case Example 1

The university medical center has UR staff, clinical case managers (all with bachelors or masters degrees), liaison home care staff, and social workers making nursing home and hospice placements. The case managers are assigned by MD services, but do not have a practice of seeing their patients or rounding with the physicians to which they are assigned.

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In fact, there was a mystery about whether the case managers received any first hand information from patients because they did not round with physicians and did not have a practice of going into the patient rooms. In a service-based model, it is even more difficult to see patients because a case manager is often going to many units trying to "track down" patients and the specifics of care decisions. Without being unit based, case managers who want to actually look under the sheets have to squeeze it in while they or the patients are constantly on the move.

Case Example 2

A unit-based case manager, responsible for UR and discharge planning, was trying to determine if the patient could receive wound care from home care. She had not been in to see the wound on the patient's buttocks, but from the chart developed a belief that with skilled nursing visits by home care, the patient's family should be able to handle the care. The case manager sat in the nursing station, trying to contact the onsite home care nurse and trying to "catch" the nurse taking care of the woman.

The case manager's coach suggested that she arrange to go and see the patient *with* the home care liaison nurse *that day* while the staff nurse was changing the wound. Within 30 seconds of being in the room, it became clear that the patient was very lethargic from a stroke, and that the room smelled from the advanced stage of the wound. It took two people just to turn the patient to be able to change the dressing. *None of this detail was in the chart.* Because of the three-way bedside observations, the case manager was then able to put together a much more realistic plan. The case manager would have eventually come to the same conclusion, but perhaps several days later.

Case Example 3

As I accompanied an onsite payer case manager to a pediatric hospital, I was anticipating an exciting clinical day of working with children and their families, physicians, nursing staff, and others as they discussed the best approach to cost and quality outcomes. Instead, the case manager had to check with admitting to see which patients were still in the hospital, then read the charts of 5 patients and gather information from their nurses. For each patient, she gave a reason why she did not need to go in the room. In one instance, the reason was that the mother was in the room with the toddler. In another, she talked with a doctor about the patient, but was using information from a staff nurse who was covering for another nurse. The doctor was very frustrated with the case manager, believing that her only agenda was to have a short length of stay.

Case Example 4

A case manager was calling the nursing home to relay that one of their residents, currently in acute care, had just expired. I expressed my condolences and asked her how the family was doing. She explained that given her current workload, she did not have time for them, and that any family was lucky to get "more than a lick and a promise" in her hospital. Sadly, this was in a small community hospital with many nurse and social work case managers, but working in a model that did not value contact. Indeed, these case managers were invisible.

Discussion

The following points are reasons given as to why case managers might opt not to look under the sheets or, in the case of disease management and other models, contact the patient directly by phone.

—Time and Caseload Constraints

Obviously, time is the major factor in the way case managers and their departments define role expectations such as how much direct patient contact a case manager should have. What a case manager does with his or her time every day is the most important and autonomous decision of the practice. As there is never enough time to do everything one would like, the choice of whether to have direct contact with patients on some kind of regular basis for specific purposes actually defines a case manager's values and ultimately, the practice.

Sometimes the patient's personality or condition makes it difficult to overcome reluctance to enter the room. One case manager described a patient who was in isolation for 2 weeks, so she did not see a need to go into the room. To her credit, she did talk to the patient's wife once regarding discharge plans.

—Screening and Referral Methods

Most case management departments, on both the payer and provider side, have a process for determining which patients have the greatest need for case management intervention. If the patient does not meet risk screen criteria, any discipline has the option to refer a patient or family for case management services. These two methods are important processes as case managers strive to conquer their workload assignments. However, sometimes the impression that there will be accurate screening and timely referrals creates a false sense of reassurance that everyone is accounted for in some way. In addition, if after the case manager responds to the screen or referral but still does not see the patient or family directly, then one must question if any value has been added to the process of determining solutions for complex situations.

—In the Name of "Objectivity"

It has been suggested that seeing the patient may make the application of criteria for appropriateness or level of care more confusing to a case manager. In other words, the argument is that a case manager would be less objective if he or she was swayed in their judgment by actually observing and speaking with the patient—sort of swept away by the gravity or emotion of a patient's situation. In other words, just reading the chart as an external payer or reviewer might do would be more of a long-term service to the employing agency than comparing the criteria to the actual patient concurrently. These are important points and need discussion within a case management department so that each case manager arrives at an understanding about the way criteria should be used concurrently. For the most part, if seeing the patient makes a case manager confused,

there is probably a good reason for it, and that reason should be understood rather than avoiding patient contact. Every case manager has had the experience in which criteria just do not fit the situation. Indeed, criteria are a guide, not a law.

—The Issue of Trust and Respect

Another issue raised about the subject is that looking under the sheets might imply that the case manager doesn't trust the staff or the staff's notes in the medical record. Indeed, this is a key consideration not only about the practice of direct contact with patients and families, but about the way case managers conduct themselves whenever they in the clinical arena. CCM has observed that the case managers that know the up to date clinical aspects of care and involve clinicians in dialogue about the condition of the patient in question do show respect of both the clinician and the complexities faced by direct care givers. In fact, to avoid patient contact could be viewed by clinical staff as disrespectful of their own work in that the case manager may be "too fancy" to share the bedside. Case managers need to dispel the image of the "nurse in heels with the clipboard."

The Argument For Seeing the Patient—at least once

1. Accuracy and Credibility

The main reason for a case manager to see the patient at least once is to increase accuracy of decision support and thus gain or maintain credibility as a cost-quality specialist. As the old saying goes, "A clinical picture (and smell) is worth 1000 words". The subjective and objective information gleaned from seeing the patient helps to win the confidence of physicians, direct care staff, and payers. Whether reviewing the patient against criteria, expediting treatment planning, or facilitating a transfer to another level of care, case managers that base these interventions on first-hand, expert knowledge will gain the most respect and usually have the easier time with meeting their goals.

2. Platform for a relationship

The second real reason for having even a brief contact with a patient (or family in many instances) is to begin a working relationship. If a case manager can begin at the beginning when situations are stressful but hopeful, things may go much smoother as the clinical course unfolds. Building a platform for a relationship before difficult decisions must be made regarding treatment, recovery, discharge, or transfer, is in everyone's best interests. Trying to facilitate complex decisions on the first encounter with a distraught, confused, stressed patient and family may result in the wrong decision. It can definitely result in less than acceptable patient satisfaction scores, and worse, it can lead to readmissions and other events signaling poor quality.

3. Advocacy

The third reason to interact with patients is that it establishes the case manager as an advocate. "The CMSA has always seen patient advocacy as [one of] the model's main missions", said Boling. "There are people who use the term *case manager*, who are focusing on cost issues alone, but that is not case management. In other words, If you are not directly involved and interacting with the patient, then it's not case management."[iii]

4. True Partner with Physicians

Good physicians have always respected good clinicians in every discipline. To be taken seriously by physicians, case managers cannot lose their clinical roots, and clinical means being with patients and, as needed, their families. Physicians will listen to and learn to trust the observations and suggestions of case managers who base their consultation on "having just seen the patient", "just talked to the family", "just watched the physical therapist work with the patient", etc.

In addition to clinical knowledge as an important foundation in partnering with physicians, case managers have to play by the same general rules expected of physicians. For legal, ethical, and other reasons, physicians are increasingly scrutinized for the amount of time they actually spend with their patients. Most health care professionals are upset by physicians who don't spend enough time with patients, or who call a consult instead of seeing the patient themselves. Much anxiety is created when physicians who don't really know the patient are covering on the weekend or evening. So why should case managers be the only group in the clinical arena for whom it is both legal and acceptable to not see the patient, at least once if not regularly?

5. Providing leadership and knowledge

Case managers can be considered "Knowledge Workers", and should make the most of the fact that they have not only a great deal of clinical experience behind them, but that they have current clinical knowledge AS APPLIED TO SPECIFIC PATIENTS. Staff of all disciplines, but in particular nursing, desperately need the knowledge that case managers possess. And case managers need to be generous in giving that knowledge, as well as in creating new knowledge that everyone can bring to bear on current patients.

Conclusion

CCM's position is that if case managers continue the practice of avoiding direct patient contact, they will soon lose all credibility and the practice will become extinct.

This position statement is offered as a beginning dialogue on a sensitive subject. It is also expressed with the larger goal of ensuring that case management continues to develop as a strategic role. Please feel free to respond via email or schedule time on the phone with either Karen Zander or Kathleen Bower, co-owners. *KZander@cfcm.com* or **508-651-2600**

Endnotes

i Cudney, A. "Case Management" *Journal of Healthcare Management*, Vol 47, No.3, May/June, 2002; p. 153.

ii Lamb, G., Stempel, J."Nurse Case Management from the Client's View: Growing as Insider-Expert", *Nursing Outlook*, Vol. 42, No 1, Jan/Feb, 1994 pp 7-13.

iii Marden, Susan, "Case Managers Face Identity Crisis Due to Rapid Growth", *Hospital News*, Massachusetts Vol. 18, No 9, Sept 2001, p 7.