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New Definition

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State of Healthcare, 2003: Teflon® Managing Jello®

An editorial by Karen Zander, RN, MS, CMAC, FAAN

My fortune cookie on New Year's Eve said, "You never hesitate to tackle the most difficult problems." My problem is that this year, words elude all of us as we try to understand problems in patient care and its management. Case managers, health care administrators, physicians and professionals that deliver direct care across the continuum, payers, and the families of our most recent patients all seem to be frozen in suspended animation or moving in slow motion through quicksand. Indeed, the visceral experience of many within healthcare is that of people with non-stick surfaces and unclear roles trying to manage gelatinous systems using outmoded tools and ambiguous assumptions. As a result, standards of care and standards of practice have been reduced to suggestions rather than rules. Healthcare in 2003 is on shaky ground. Let me explain this view.

Indeed, the visceral experience of many within healthcare is that of people with non-stick surfaces and unclear roles trying to manage gelatinous systems using outmoded tools and ambiguous assumptions.

Consultants are exposed to many situations, not all planned. However, in the past few months, I have witnessed situations unlike any before. They cover discussions about whether operating room nurses really have to count sponges after surgery, whether respiratory therapists are authorized to explain a standard vent weaning protocol to a family, whether head nurses have the skills to lead patient care rounds on their own units, and whether social workers in a pediatric hospital should find a way to quickly contact and assess most families. I was told by one home care nurse that she wasn't going to discuss the need for additional physical therapy for a patient she shared with PT, because she "wouldn't want the PT to tell me how to change a dressing." I have heard a 92 year old woman and her family, devastated by emergency bowel surgery, counseled by physicians to "think of her new colostomy bag as a Gucci bag." I see case managers avoiding physicians, and physicians avoiding case

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managers. I see piles of data with no synthesis, analysis, or follow-up. I see huge, important organizational quality and financial targets, but no strategy to accomplish them; the private sector has adopted the government concept of "unfunded mandates."

Mostly, I see a lack of a sense of urgency on the part of clinicians to manage their patients' outcomes, and on the part of administrators for improving the work conditions and investing in the development of their clinical professionals. There is a growing crisis in which the essential knowledge workers cannot keep up with the knowledge *or* the work. People in all positions within health care seem highly distracted from the core business of giving patient care as smartly and compassionately as possible. They are looking for leadership, for leaders that will clarify values and invest in the implementation of priority changes within the framework of an honest mission and a healthy margin.

A Symptom: Non-stick Case Managers

Case management "as a formal discipline", has emerged in its current form due to "the complexity of our healthcare system, combined with increasing pressure to conserve finite clinical resources".[i] Logically, then, looking at the practice of case management provides insight into the larger healthcare scene. Basically, case managers need to custom-design a network around patients for whom there are no simple solutions. However, even the best case managers are being challenged greatly. It takes very skilled case managers to navigate the slippery structures (or lack of structure) both inside and external to the organization for which they work.

One troublesome component of the current environment is the less-skilled case manager to which nothing sticks. Basically, non-stick case managers don't get involved when it comes to managing or coordinating decisions. They come when paged, but never initiate action until there is a crisis. They usually stay on the outside of an issue. Their peers know this, and as a result expect less and less from them.

When this non-stick phenomenon was presented at a recent conference[ii], participants helped describe it in more detail:

- The case manager who has no concept of risk, such as why patients who are very obese might pose problems, or why a patient who has fallen in the hospital might require special attention from case management
- The case manager with no knowledge of clinical evidence, such as the case manager that authorizes discharge for a diabetic who will need a special wound dressing about which the case manager is unfamiliar.
- The case manager bureaucrat, the one that wants families to sign forms and make decisions without having established a working, trusting relationship first.
- The case manager that attends rounds and meetings, but takes no authority to clarify or provide factual support for decisions
- The case manager that knows and mentions problems but passes them off to others. When patients and problems are "out of sight," they are also "out of mind."

The challenge is determining what part of non-stick is the person themselves, and what behaviors are caused or supported by today's environment.

Understanding Causes – A Case Study

In recent discussion, many causes for the gelatinous nature of our organizations have been suggested. Perhaps the cause of the anxiety and distraction is downsizing, ineffective mergers and acquisitions, or the nursing shortage getting too extensive. Maybe managed care did not go far enough, or went too far. Maybe it is all due to September 11. But the example above of the home care nurse who did not want to talk about the patient's need for continued physical therapy with the physical therapist points to some potentially "fixable" issues. Although the following is a home care example, these causes and remedies can be transferred to acute care and other care settings:

1. The RN did not see herself as either the primary case manager, or the nurse of the patient over time. She saw herself as someone assigned to the patient to do dressing changes, not to manage toward synergistic outcomes by creating a team of other professionals around the patient.
2. The agency did not expect teamwork. It hired individual professionals who happen to be on the same case. It assumed they would communicate with each other as needed.
3. The PT and the RN had separate plans of care, completed on admission and not formally revised until 60 days required another care plan.
4. The agency had computerized notes, but some RNs and PTs read them, some did not. Per diem professionals received paper print outs of old information. Some brought computers into the home, some did not.
5. Almost everyone is part time, covering for the person covering for someone else. Even the supervisors are part time. They don't know the patients, or each other.
6. Neither the PT nor the RN were really patient centered—they each were profession-centered and task oriented.
7. In addition, they do not have an understanding of clinical indicators for evidence-based practice, which would help them mutually and objectively determine if the patient was meeting criteria in a timely way, and if the generally accepted standards are being followed.
8. As a result, the family is often put in the middle of this confusion, being expected to say whether the PT should continue to make visits. The professionals seem to refer to family wishes when they are at a loss for direction. The family has no recourse, and is faced with trying to navigate

a health care system that responds paradoxically like jello, but with the unpermeability of steel.

9. The staff and management do not distinguish between care following and care managing.[iii]
10. The staff and management do not differentiate delegation from inclusion. Delegation tends to involve transferring responsibilities for actions to others, usually from someone with more employment status to someone with less status. Inclusion may result in the same transfer of responsibility, but entails consensus brought about by information, respect, and reciprocation.

The point of trying to understand such situations is not to place blame, but rather to find immediate, tangible ways to change the behavior and support positive behaviors of professional people who are working in increasingly chaotic situations. Although written about nurses, the following refers to anyone working in health care today:

> *"The thinking that caused the problem is inadequate for solving the problem."*
>
> —Einstein

"It is all too easy to blame "them"—administration, the CEO, insurance companies, nurses working in other areas, for the current state of the landscape of nursing. The problem with the "blame game" is that nobody ever wins. People feel victimized and helpless, and all the energy expended doesn't solve the problem. Einstein once observed that the thinking that caused the problem is inadequate for solving the problem. Nurses who want nursing to improve need to change the way they think about nursing, themselves, and other nurses."[iv]

New Year's Resolutions

The first step in changing the way professionals think about themselves is ***to build a different environment of expectations and acknowledgements***. Paramount to this endeavor is the establishment of an infrastructure of continuity and accountability. New tools, roles, and relationships can then be developed. Case managers, physicians, administrators, and caregivers cannot do it alone. I offer 10 building blocks to launch 2003:

1. Value "holding the patient's story"[v] as a precious commodity and obligation
2. Make continuity of assignments within and between shifts (or visits as in home care) a priority
3. Ensure case manager to case manager transfer of information between units, and between agencies. Verbal transfer (in person or voice mail) is always an enhancement to written forms and documents.
4. Give someone authority to pull a team together when there needs to be a team.
5. Don't make your first encounter with physicians, patients and families one of confrontation (i.e. "she can't stay here any longer")
6. Realize the enormous difference between teaching, telling, and scolding patients and families.
7. Don't forget to revise and use performance appraisals to address new, wanted behaviors.
8. Don't spread managers too thinly across settings.
9. If you give a group or person new responsibilities, give them the necessary training.
10. Find positive ways to hold people accountable for results (outcomes) of their tasks.

Endnotes

i Cudney, A. "Case Management: A Serious Solution for Serious Issues", Journal of Healthcare Management Vol 47, no 3, May/June 2002, p. 149.

ii Zander, K., "Case Management Administration: Building the Case", Case Management Along the Continuum by Contemporary Forums, Boston, MA., October 6, 2002.

iii Zander, K., "Responsive Restructuring Part III: Turning Care Following into Care Management", The New Definition Vol. 9 (1), Winter, 1994, pp 1-3.

iv Losee, R. "Interior Rededication", Nursing Spectrum 2003 Career Fitness Guide, p 132.

v From J.Somerville, CCM, 1999.

Coming in the next issue ***A Guide for Clarifying Roles in Managing Care: Plans for the Day, the Pay, the Stay, and the Way***