THE CENTER FOR CASE MANAGEMENT

New Definition

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Upgrading Case Management to Prevent "Maxing Out"

Introduction

Case Management in acute care has been gradually gaining momentum as a respected and increasingly large department. One needs only to look at the amount of books and journals being published on the subject to realize that Case Management is here to stay for some time. However, The Center for Case Management (CCM) finds that there is a broad range of distribution and functionality across the United States. CCM also finds that case management departments that only add staff and do not otherwise upgrade the service have not been able to make substantial changes in Length of Stay, cost per case, denials, satisfaction, readmission rates, or other targets. In other words, there may be a point at which case management can no longer produce new results. In the words of D. Berwick, "All organizations are perfectly designed to produce the results they get,"[i] and that applies to case management as well as the larger organization.

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To achieve new results, directors of Case Management have moved past business as usual to truly "push the envelope" by identifying and negotiating the conditions necessary to make case management a strong service. It should be stressed that they do this for sanity and success, not for ego! In fact, in the most successful hospitals, a case management director that will go "toe to toe" with administration to discover important new processes and opportunities is highly respected as a steward of resources and internal barometer/integrator. The tools, roles, policies, and operations that these directors seek do not happen all at once, but evolve as they discover and/or create key leverage points. Without some or all of these leveraged "moves", even the addition of more staff would not have helped them meet the every-changing and intense targets. Without operational upgrades to a case management service, it is at risk of maxing out.

Is Case Management Maxing Out?

Historically, Case Management in the hospital has never had much synergy with other departments. Although its roots are in medical necessity and the need for discharge planning, case managers and social workers have no legal authority to write orders for either of those two purposes. Indeed, they can only provide decision support to the doctors, nurses, and multidisciplinary teams. They have the privilege and challenge of working *through* others; i.e., when case management is working well, case managers and social workers are pacers of care, problem-solvers, and peace-makers. As a result, case management and clinical social work can be lonely and exhausting work. As Jackie Birmingham states about the roles, "Be prepared for many patients that don't have resources, and all have some type of serious need."[ii]

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Whether the various functions within the case management department are integrated into one role or separated into several roles, there is almost always a struggle between those in case management and at least some of those professionals that case management is supposed to be influencing. I have seen hospitals with twice the case management staff be less effective than those with half the staff. I have heard countless questions and many philosophies around issues such as how to assign staff, how much should be documented, how to create good will between staff nurses and case managers, between social workers and case managers, between the business office and case management, between doctors and case management, between doctors and doctors, etc. Some questions have no definite answers and will continue to be asked because case management is meant to be a flexible and fluid service that adapts to the conditions of the specific employer. On the other hand, some of the questions must be raised in an effort to explore the boundaries of responsibilities and accountabilities for the otherwise amorphous enterprise of providing case management services.

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Can you ever have enough staff in case management and social work? Perhaps not. The sense of "enough" depends on everything else and everybody else. Without addressing at least three of the many barriers to truly integrating case management into the life blood of the organization, case management will essentially plateau its effectiveness and max out.

Three Big Barriers

Of the many barriers to a truly effective case management department, three are suggested here. The biggest barrier is that the Executive Team as a whole(CEO, CNO, COO, CFO, and Vice-Presidents) does not really know or understand what Case Management should be doing for the hospital, and does not know how to support it. The second big barrier on which case management maxes out is the classic medical model, which at its worst excludes all input and devalues interventions from non-physicians while exclusively supporting the physician as sole decision-maker. Many hospital and health system administrations are only recently beginning to build bridges of trust and expectation with the physicians. The third barrier is that most hospitals are still not operating as a 24/7 operation.

Of course, these barriers are only a few of the many other causes of frustration and ineffectiveness within case management. And indeed, some services do need more staff, or a different redeployment of the same staff. But regardless of the staffing numbers, there are ten broad-reaching changes that can prevent case management from maxing out. These changes could be considered upgrades, or very simply, power moves.

Ten Upgrades for Case Management Directors to Consider

1. **Targets** Create a Data Dashboard (also called Value Compass or Balanced Scorecard or DataMap®) that is negotiated with and authorized by the Executive Team.[iii] Then implement strategies to accomplish each quantified goal and decentralize accountability for the goals to specific staff.[iv]

2. **Customers** Know enough about the reasons for your hospital's current cost-quality state to make the CFO, the COO, and the CNO your customers. In other words, be the "go-to" person when they are seeking information, explanations and solutions. It is mandatory to know your contribution(s) to the revenue cycle!

3. **Medicare** If you structure and manage the department using best practices for Medicare patients (regardless of Medicare's percentage of your payer mix), you will most likely have a best case management practice for all patients. Put at least one nurse case manager in the ER and start to cover the hospital on weekends with a case manager and social worker. [Workshops and audits available from CCM]

4. **Medical Director** Refuse to be responsible for a case management department without a solid or heavily dotted line to the VPMA and, if your organization is large enough, a partner of the Medical Director/Physician Advisor (PA). Send the Physician Advisor for training, and structure the time commitments and results for which he/she is getting paid. Outsource for a Physician Advisor (PA) if necessary. Co-lead Complex Care Rounds with the PA. Re-organize the UR committee as such and integrate it into all other cost-quality structures. [Consult available from CCM]

5. **Competencies** Use operational algorithms to teach and explain the roles, responsibilities, and relationships between the staff and the rest of the system. Then use CCM's new set of Competencies to identify how each of the staff can develop their practice. [Algorithms and Competencies available through CCM]

6. **Nursing** Build bridges with nursing administration and between each case manager and the nurse managers whose units they cover. The first bridge for them to implement collaboratively is daily Care Coordination Rounds. Consider unit-based assignments, which have been found to be the most efficient and stabilizing.[v] Along the same lines, work with administration to make it easy for physical therapy to see patients, document, and collaborate with case managers.

7. **Social Work** Have enough Masters-prepared social workers to partner with and support every two case managers, but only if you transition social work from a referral service to a case-finding practice. Get the social

workers out of discharge planning exclusively and into clinical social work in which every family is briefly met with and screened, family expectations are managed, and family meetings are held frequently. [Transition training and tools available from CCM]

8. **Liaisons** Restructure so that all liaisons from the post-acute network owned by the hospital or system report to you or at least to the same VP that you do.

Most importantly, get outside your office and away from your computer to spend the majority of time with your staff or with the execs.

9. **Facetime** Create more face time, less desk and chart time for the case managers and social workers. It is imperative they have direct contact with all their patients and families.
10. **Be a Presence!** Most importantly, get outside your office and away from your computer to spend the majority of time with your staff or with the execs.

For more information about why, when, or how to create these changes, make a free phone appointment with Karen Zander or Kathy Bower at The Center for Case Management. Or, come meet Karen and Kathy this spring at

- ✓ AONE, Chicago (April 15-19), and Karen at
- ✓ CMSA, Orlando (June 21-24)
- ✓ ACMA, Chicago (April 24-27)

Endnotes

i Berwick, D., Boston: Institute for Healthcare Improvement

ii Birmingham, J. quote from "Getting Into Case Management," Nursing Spectrum Seminars, 2002-04.

iii Hill, M, and Zander, K. DataMap in *New Definition*, Spring 2001, *cfcm.com/resources*.

iv Examples: 1) Do external audits for avoidable days, 2: eliminate productivity tallies of social work, etc.

v Warren, C and Zander, K. "Converting Case Managers from MD/Service to Unit-based Assignments: A Before and After Comparison", manuscript submitted for publication.