The Case Manager's Survival Guide

Winning Strategies in the New Healthcare Environment

Third Edition

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The Case Manager's Survival Guide

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Foreword

As healthcare spending continues to rise, quality of care is questioned, and consumers strive to take a more active role in their health and healthcare, payers and providers have an urgent mission to address. They must find specific ways to control costs, address quality gaps, stem the tide of chronic diseases, and deliver care that meets the needs, but more importantly the goals, of each consumer they serve in an efficient manner.

No one person can tackle these challenges alone, but a fully engaged collaborative team can. Organizations must educate and empower their teams to work together. These collaborative teams work toward a common goal that meets the demands placed on quality, outcomes, and patient satisfaction that will impact their organizational goals and survivability.

The professional case manager is the one objective member of the team who can bring together the various professionals who make up today's interdisciplinary healthcare team to address cost, quality, safety, and access: the four pillars of a successful healthcare organization or system.

The role of the case manager is to identify patients (consumers) who are at increased risk, work to break down barriers that impact their ability to manage their own health and healthcare, and ensure they have the resources to meet their individual needs. To be effective, case managers must always have their "finger on the pulse" and be able to address challenges that come from various stakeholders, including the consumer, in a creative and knowledgeable manner.

Professional case managers must be clinically competent, understand the changing dynamics of the healthcare system, be patient and family centered, and be able to communicate effectively with each member of the healthcare team, especially patients and their caregivers.

The Case Manger's Survival Guide: Winning Strategies in the New Healthcare Environment by Toni G. Cesta and Hussein M. Tahan delivers a resource that each member of the interdisciplinary care team can use to gain insight into what effective case management is and how it should be delivered irrespective of the setting.

The authors share their collective expertise as clinicians but also as leaders in the profession of case management in this comprehensive textbook that should be on every case manager's shelf. They challenge case managers to take their place at the table to ensure the consumer is the central member of the team and has a voice in all aspects of their own care.

Through their writings, the authors provide information that will educate and empower readers with tools and strategies to improve their practice and to achieve the outcomes necessary to remain relevant in today's dynamic and competitive healthcare system.

This textbook is to be used by leaders in healthcare as they redesign systems to meet regulatory, accreditation, and reimbursement challenges that providers and payers face as we move into an accountable care environment where value replaces volume.

This textbook is a valuable resource to those new to the profession of case management as well as those currently in the practice. Healthcare is changing with new care models replacing existing ones to contain cost and improve the quality of care.

This textbook provides essential information that each professional can use to meet the industry's demands. The material will strengthen case management programs and provide organizations with ways

to prove their value through the outcomes produced. It serves as an educational tool for academics and professionals involved in continuing education charged with clarifing what case management is and what case management can be.

This textbook also provides a resource that directors and supervisors of case management programs can use to reinforce the fundamentals of the practice to experienced case managers and introduce concepts as new professionals move into the the practice of case management.

As a leader in the practice of case management, I know you will find this textbook a great investment to help you understand and address the challenges you face in the exciting yet disruptive world of today's healthcare system. Use it well!

I would like to thank the authors for asking me to write the Foreword for *The Case Manager's Survival Guide: Winning Strategies in the New Healthcare Environment*. It is an honor for me as a case management leader and someone who has recently experienced first-hand how the healthcare system works or rather does not work.

I thank Toni and Hussein for pouring their passion and expertise into this textbook. It is our hope the information provided on each page improves the care delivered to each patient who enters the complex healthcare system through your practice of case management.

Anne Llewellyn, RN-BC, MS, BHSA, CCM, CRRN
Nurse Advocate

Preface

It has been ten years since we published the last edition of the "*Case Manager's Survival Guide: Winning Strategies for Clinical Practice.*" So much has changed in the field of case management, the Medicare and Medicaid benefit programs, and the U.S. healthcare delivery system in general. Terms like coordination and transitions of care and the healthcare continuum have become common parts of the language of healthcare. Bundled payments, accountable care organizations, and the patient experience of care have driven the increased need for case management across the continuum, today and going forward.

It is without a doubt that case management is one of the strategic interventions that is most needed to assist healthcare organizations and providers in balancing the quality of the care they provide to patients and their support systems with the reimbursement they receive. It is also without a doubt that case managers are necessary at every level of care across the continuum. And finally, it is without a doubt that case managers must communicate and transition patients across care settings and providers with a critical eye on quality, safety, care experience, and cost.

It is for these reasons that we have written the third edition of the "Survival Guide." We have heard from you, our readers, our students and our colleagues, and we have responded with our most comprehensive textbook yet. Building on the first two editions and adding ten years worth of updates have resulted in a textbook that takes you, the reader, from the beginnings of our wonderful specialty profession to the present day and beyond. We feel that it is also time to update the title so that it is consistent with the changing healthcare landscape. We therefore have chosen "*The Case Manager's Survival Guide: Winning Strategies in the New Healthcare Environment.*" We believe that this title better reflects the third edition's focus on the new world of healthcare that we live in.

As with our other editions, this one combines practical knowledge with a theoretical framework that allows each reader to take from it the specific components they believe they need to enhance their own work and performance as case managers, interdisciplinary healthcare team members, and colleagues. As always, we hope that you find the "Survival Guide" useful in the ways we designed it; ultimately it is our goal to contribute to the improvement of patient care wherever our patients may seek it.

We hope you enjoy reading this textbook as much as we have enjoyed writing it!

Toni G. Cesta, PhD, RN, FAAN
Hussein M. Tahan, PhD, RN

1 Introduction to Case Management

If you have purchased or borrowed this book, you must be a case manager, or you are thinking of becoming one. If you are *already working* in the field, you are probably beginning to experience many of the conflicts and confusions that come with this role. If you are *thinking of becoming* a case manager, you are probably reading as much as you can about this delivery system and the role you will play in it.

Because case management is relatively new to many nurses and social workers, it may be difficult to find other nurses working with you or colleagues who have been case managers. Although there are tens of thousands of case managers across the country, there may not be many in your organization or your part of the country. This book is written with you in mind. Although the book's overall objective is to provide comprehensive information on the role of the case manager and on case management, its format is designed so that it is a ready reference for the on-the-job questions and issues you may face every day.

The case management process is often an intangible one—a behind-the-scenes process and outcomes role that is, at its worst, very stressful and, at its best, very rewarding. The role is complex and eclectic. Not for the meek or mild, it requires confidence and comprehension of a vast array of topics, many of which are reviewed in this book.

Although case management has become somewhat of a household word in healthcare, there is still a tremendous amount of confusion about what it is, how it applies to various settings, how its success can be measured, and what the role of the case manager is (Box 1.1). As a profession, we have yet to answer all of these questions consistently. There are core components of the model and of the case manager role that can be taken and applied in a variety of ways. The objective is to find what works best for you and your organization without losing the essence of case management.

Box 1.1 Commonly Asked Questions About Case Management

1. What is it?
2. How does it apply to various healthcare settings?
3. How can its success be measured?
4. What is the role of the case manager?

1.1. USING THIS GUIDE

The purpose of this book is to provide the hands-on information you will need to be an effective and successful case manager. This book contains a lot of information that can be used in the study of case management and in the implementation of case management models. To be a successful case manager you need to understand the role itself, but you also need to understand how case management fits into the bigger pictures of healthcare delivery, healthcare reform, and the future of healthcare. Pick up this book whenever you have a general or specific question. Use it as a ready reference as you develop your expertise in case management.

Broad topics are addressed, and their specific implementation techniques and strategies follow. It is important to understand both the concepts and their application. We suggest that you review both.

1.2. HEALTHCARE INDUSTRY UNDER HEALTHCARE REFORM

The healthcare industry continues to be in crisis—a chronic crisis of epic proportion, and brought about by many factors (Box 1.2). Both the prospective payment system and managed care infiltration have necessitated a reassessment of the industry's work, how it is organized, and how it is evaluated. Healthcare reform has now added to the need for reassessment of the business of healthcare. The process of getting reform in healthcare was a long one taking over 20 years. Reform was a major issue for the presidency of Bill Clinton. The first program of reform introduced by Hillary Clinton in 1993 was not enacted into law. During the Bush administration, several acts introduced were aimed at reducing the overall growth of healthcare costs. Other programs looked at proposals to guarantee access to coverage in the individual health insurance market and for improving the quality and safety of the U.S. healthcare system. These programs continued to be debated through the 2008 presidential election by candidates McCain and Obama.

The game changer came in 2009 when the Congressional Budget Office (CBO) issued a preliminary analysis for the Patient Protection and Affordable Care Act. The CBO estimated the 10-year cost to the federal government of the major insurance-related provisions of the bill to be approximately $1 trillion (Congressional Budget Office, 2009.) It also provided for a reduction in the number of uninsured by about 16 million people. After President Obama was inaugurated, he announced his intent to work with Congress to construct a plan for healthcare reform. The Senate developed its own proposals while the House of Representatives worked on the Patient Protection and Affordable Care Act. After debate in both the Senate and the House, and after many versions of the bill, it was finally voted into law on March 23, 2010. The amended bill was titled The Health Care and Education Reconciliation Act.

The Health Care and Education Reconciliation Act ensures that all Americans have access to quality, affordable health insurance and puts students ahead of private banks. The CBO has determined that together these two bills are fully paid for and will ensure more than 94% of Americans have access to quality, affordable healthcare, will bend the healthcare cost curve, and will reduce the deficit by $143 billion over 10 years with further deficit reduction in the following decade.

Box 1.2 Factors Affecting the Healthcare Industry

1. Changes in healthcare reimbursement
2. Increases in auditing by the Centers for Medicare and Medicaid Services
3. Links between cost and quality of care
4. An aging patient population
5. Over-crowded emergency departments
6. Continuosly rising costs
7. Shortages of some types of providers
8. Increasingly complex and chronic illnesses
9. Lack of coordination across the continuum of care
10. Technology, including advances in surgical procedures such as robotics and minimally invasive surgery
11. Information technology such as electronic medical records and physician order entry
12. Educated patients as consumers of healthcare

1.3. VALUE-BASED PURCHASING

Value-based purchasing has added another significant change to the business of healthcare. The Centers for Medicare and Medicaid Services (CMS) have instituted linkages between cost and quality through value-based purchasing and other cost-saving measures such as payment penalties for high readmission rates. These changes have created the first links between the cost and quality of healthcare. Many hospitals and health systems are now testing bundled payment methods and accountable care organizational structures which will be discussed in Chapter 2. While the entire act does not directly relate to case management, many of its elements do, whether directly or indirectly. The changing demographics of the patient population have forced us to re-examine our values and our expectations or expected outcomes of the work we perform particularly as they relate to patient care. These changes have come about as a result of an aging patient population with a concomitant increase in chronic illnesses and a more educated patient as the consumer of healthcare. Technology, including medical informatics, has driven up the cost of healthcare. The advent of the electronic medical record has been a positive change for the healthcare industry, but one that has resulted in higher cost. It is hoped that eventually these hardwired electronic processes will reduce errors and associated costs due to these errors in the following ways:

- Improve care quality, safety, efficiency, and reduce health disparities
  - —Quality and safety measurement
  - —Clinical decision support (automated advice) for providers

  - —Patient registries (e.g., ”a directory of patients with diabetes”)
- Improve care coordination
- Engage patients and families in their care
- Improve population and public health
  - —Electronic laboratory reporting for reportable conditions (hospitals)
  - —Immunization reporting to immunization registries
  - —Syndromic surveillance (health event awareness)
- Ensure adequate privacy and security protections (Centers for Medicare and Medicaid Services, 2011)

In 2015 hospitals began to receive financial penalties for not using electronic medical records as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Complex, high-tech and minimally invasive surgery; expensive, life-prolonging treatments such as kidney dialysis; costly antibiotics; computerization; and the need for more and more durable medical equipment to support the care and recuperation of the elderly and the chronically ill have all contributed to escalating costs as we have never seen before.

In recent years, emergency departments have become overcrowded and congested resulting in patient flow, safety, and quality of care issues. As the CMS have moved to different payment methods, negative issues surrounding coordination of care across the continuum have become more obvious. Lack of coordination across the continuum haved affected readmission rates, cost of care, quality, and patient satisfaction, and have required new analysis and interventions of care coordination. While coordination of care has always been a foundational role of case management, it has only become part of the vernacular of health care in recent years.

The frenzy of activity going on in every healthcare setting across the country is an indicator of the need to bring massive and significant change to the industry. Many of the changes involve cost-cutting efforts that many criticize as compromising the quality of care. Managed care is one change that has been consistently criticized for its cost-cutting approach that has appeared to be less concerned with quality of care (Curtin, 1996; Kongstvedt, 2001). Other changes are intended to control both cost and quality. Case management is one such effort. It is designed to manage care, which results in a monitoring and control of resources and cost regarding management of the resources applied and the cost of the care. It is also designed to be an outcomes model, and it has, as part of its methodology, a close monitoring of the products of the care it manages and their effects on the patient and family. Case management is not equivalent to managed care. They are not interchangeable concepts or phrases. Whereas managed care is a system of cost-containment programs, case management is a process of care delivery sometimes used within the managed care system.

1.4. HISTORY OF CASE MANAGEMENT

Case management is not a new concept. It has been around for more than 90 years (Box 1.3). As a means of providing care, it originated in the 1920s out of the fields of psychiatry and social work and focused on long-term, chronic illnesses that were managed in the outpatient, community-based settings. Case management processes were also used by visiting nurses in the 1930s. The original public health nursing models used community-based case management approaches in their care of patients (Knollmueller, 1989). As a care delivery system, case management is a relatively new concept to the acute care setting, having developed and flourished in the mid-1980s. Between the 1930s and the 1980s the model remained essentially in the community setting. It was not until the introduction of the prospective payment system that the model shifted to the acute care, hospital-based setting.

1.4.1. Definition of Case Management

Whether case management is being applied in the acute care, community, or long-term care setting, its underlying principles and goals are consistent. As a system for providing patient care, case management is designed to ensure that quality care is provided in the most cost-effective manner possible. This is accomplished by improving the processes of care delivery, making these processes more efficient and effective. Other strategies involved include the management of product and personnel resources. By better administration and control over the ways in which care is provided and the resources used, outcomes can be achieved while ensuring that quality is maintained or improved.

There are a variety of definitions of case management, including the following:

- “A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes,” (CMSA, 2010).

Box 1.3 Coverage, Medicare, Medicaid, and Revenues (Finance Committee Provisions)

Coverage

- Makes plans in the Exchange more affordable by further limiting the cost of premiums and cost-sharing for individuals under 400% of poverty (a family of four with income less than $88,000). Ensures that if costs grow faster than expected, the amount of tax credits will be reduced to more closely track the overall inflation rate.
- Modifies the assessment that individuals who remain uninsured pay by exempting income below the filing threshold. The individual assessment is the greater of a flat dollar payment, which has been lowered, and a percentage of income, which has been raised, as compared to the Patient Protection and Affordable Care Act.
- Improves the employer responsibility provisions.
  - —Large employer penalty cap raised from $750 per worker to $2,000 per worker.
  - —Strikes the penalty for waiting periods between 60 and 90 days.
  - —Counts full-time equivalents toward the threshold for triggering a penalty, but does NOT impose any penalties for part-time workers.
  - —Phases in the penalties as employers become larger by discounting 30 full-time workers from the per-worker penalty, eliminating a disincentive to creating new jobs.
  - —Eliminates the special rule for construction industry employers.

Medicare

- Provides a $250 rebate for beneficiaries who hit the coverage gap or "donut hole" in 2010 and fills the donut hole for brand and generic drugs by 2020.
- Reduces Medicare Advantage overpayments in a targeted way that reflects the different needs of urban and rural areas. Provides a more refined approach that varies rates by local fee-for-service costs on a sliding scale. Includes 3–7 year phase-in and increases Medicare Advantage benchmarks for high-performance plans. Ensures that Medicare Advantage plans spend at least 85% of revenue on medical costs or activities that improve quality of care.
- Lowers Medicare Disproportionate Share Hospital (DSH) cuts in the Patient Protection and Affordable Care Act from $25.1 billion to $22.1 billion and revises market basket updates to hospitals by $9.9 billion.
- Adjusts the utilization rate changes included in the Patient Protection and Affordable Care Act to take into account the Centers for Medicare and Medicaid Services imaging rule that went into effect on January 1, 2010. Sets the assumed utilization rate at 75% for the practice expense portion of advanced diagnostic imaging services.

Medicaid

- Equalizes and increases funding for the Medicaid expansion by providing 100% federal match in 2014, 2015, and 2016; 95% match in 2017; 94% match in 2018; 93% match in 2019; and 90% thereafter.
- For early expansion states, provides additional federal funding to reduce the cost of covering nonpregnant childless adults beginning in 2014. In 2019 and thereafter, all states will bear the same costs for covering nonpregnant childless adults.
- Increases payments for Medicaid primary care to Medicare rates in 2013 and 2014 and provides full federal support to do so.
- Lowers the reduction in federal Medicaid DSH payments in the Patient Protection and Affordable Care Act from $18.1 billion to $14.1 billion over 10 years.
- Increases funding for the territories by $2 billion and provides territories the option to establish an Exchange.
- Delays Community First Choice Option for one year.
- Narrows the definition of new drug formulations for purposes of applying the Medicaid drug rebate.

Fraud, Waste, and Abuse

- Establishes new requirements for community mental health centers to prevent fraud and abuse.
- Modifies Medicare prepayment medical review limitations.
- Increases funding to fight fraud, waste, and abuse by $250 million.
- Requires a 90-day period of oversight for initial claims of Durable Medical Equipment suppliers.

Revenue

- Delays implementation of the excise tax on high cost health plans until 2018; increases the thresholds for imposing the tax to $10,200 for self-only plans and $27,500 for family coverage. Adds adjustments for age and gender of enrollees.
- Delays the establishment of a $2,500 cap on FSA contributions until 2013.
- For individuals with adjusted gross income above $200,000 for a single taxpayer and $250,000 for a married couple, equalizes the Medicare contribution treatment for earned and unearned income.
- Closes the "black liquor" loophole that allows certain taxpayers to get an unintended tax credit for cellulosic biofuels.
- Establishes, in statute, the "economic substance doctrine" to prevent the use of transactions that generate tax benefits but which otherwise have no business purpose.

Higher Education Provisions Under the Finance Title

- Provides $2 billion for community colleges to develop and improve educational or career training programs.

- "A professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim' of improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare," (CCMC, 2015).
- A nursing care delivery system that supports cost-effective, patient-outcome-oriented care (Cohen and Cesta, 1997).
- A role and process that focuses on procuring, negotiating, and coordinating the care, services, and resources needed by individuals with complex issues throughout an episode or continuum (Bower and Falk, 1996).
- Case management is a system of healthcare delivery designed to facilitate achievement of expected patient outcomes within an appropriate length of stay. The goals of case management are the provision of quality healthcare along a continuum, decreased fragmentation of care across settings, enhancement of the client's quality of life, efficient utilization of patient care resources, and cost containment (American Nurses Association, 1988).
- A multidisciplinary clinical system that uses registered nurse (RN) case managers to coordinate the care for select patients across the continuum of a healthcare episode (Frink and Strassner, 1996).
- A process of care delivery that aims at managing the clinical services needed by patients ensuring appropriate resource utilization, enhancing the quality of care, and facilitating cost-effective patient care outcomes (Tahan, 1999).

1.4.2. Care Coordination

Care coordination has recently become a popular term, although different, often replacing the use of the term case management. The work of the National Quality Forum (NQF) in the mid-2000s gave rise to care coordination and legitimized its use and value for the effective management of patient care and healthcare services. However, experts argue that coordinating care is one function of case management and is integral to implementation of the case management plan of care. Care coordination is the provision of personalized, quality, and safe care to patients and their families across the continuum of health and human services. A case manager may achieve this through effective integration of services and personnel from various care settings, professional disciplines, and the optimal use of health information technology systems especially for communication and transfer/sharing of important information.

NQF (2010a, 2010b) defined care coordination as a function that helps ensure the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination of care maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality experiences and improved healthcare outcomes. It also identified five key domains of care coordination as follows:

1. *The healthcare "home"*: A setting or provider (e.g., practitioner, a community health center, a hospital outpatient clinic, or a physician practice) committed to organizing and coordinating care based on patients' needs, preferences, and priorities; communicating directly with patients and their families; and integrating care across settings and clinicians/practitioners.
2. *A proactive plan of care and follow-up*: A written plan that anticipates patient's needs and tracks progress toward achieving goals. It serves as a central care coordinating mechanism for all patients, families, and care team members and as a guidepost between clinician-driven care and patient self-management. It also is vital during handoffs and transitions of care, because it can serve as the main communication document between clinicians and care settings and outline elements such as the medication list, follow-up steps, identification of care problems, and resources needed.
3. *Communication*: Open and ongoing dialogue among members of the care team, the patient, and his or her family, primary care provider, and nonclinical resources in the community. This entails the care team, patient, and family agreeing upon and working within the plan of care, sharing important information, making decision, and maintaining privacy.
4. *Health information systems*: Technology systems that support patient care, patient engagement and education, communication, and performance measurement. Specifically, technology should provide a foundation for the healthcare home, such as providing important patient information to members of the care team across various stages of care and settings; support meaningful clinician-patient communication; enable timely and accurate performance measurement and improvement; and improve accessibility of the care team to critical patient health information.

5. *Transitions of care*: Systems that engage patients and families in self-management after being transferred from one care setting or provider to another along the continuum of health and human services. A key strategy here is open, timely, and purposeful communication among the parties involved to enhance patient safety during the transition, and reduce the risk for medical errors or rehospitalizations.

1.4.3. Guiding Principles for Case Management Practice

The practice of case management is based on a number of guiding principles which aim to enhance the value of healthcare delivery and services for all: the clients/support systems, providers, payers, employers, regulators, advocates, and other stakeholders. When designed and implemented in an effective and successful way, case management programs and roles:

- Ensure patient's needs and preferences for health services and information are understood and shared across the involved parties and sites of care at all times and as the patient navigates the healthcare system.
- Result in articulating a proactive plan of care for the individual patient to be used by the patient, family members and caregivers, and healthcare team members.
- Are important for every patient; however, some populations (e.g., children with special healthcare needs, the frail elderly, those with multiple chronic illnesses) are particularly vulnerable to fragmented, uncoordinated care.
- Contribute to organizational or program's strategy for improving quality, safety, and reducing cost.
- Communicate where the responsibility for care lies—the primary care provider (e.g., physician, nurse practitioner, physician assistant, ambulatory clinic) in concert with the rest of the interdisciplinary care team.
- Support the patient centered medical home (PCMH) and other primary care or accountable care programs.
- Ensure the provision of culturally competent and patient-centered, safe care.
- Maximize the value of services delivered to patients and their families.
- Facilitate efficient, safe, cost-conscious, and high-quality patient and family experiences including patient engagement for effective self-management and adherence.
- Improve healthcare outcomes (e.g., clinical, financial, functional, satisfaction).
- Employ innovative information technology systems that ensure removal of barriers and allow for seamless and timely communication across providers, care settings and patients, families, or caregivers.
- Build effective partnerships among healthcare providers across the continuum of care (e.g., hospital and primary care settings), other healthcare organization and community-based resources and leaders.
- Place special emphasis on safe and effective handoffs and transitions of care.
- Adhere to regulatory and accreditation standards.

1.4.4. Case Management and the Role of Case Manager

It is difficult to separate the model of case management from the role of the case manager. Case management as a model provides the system, but it is the case manager who implements the model and makes it come alive. In other words, the model provides the foundation and organizational structure within which the case manager role is implemented. This may be the reason for the added confusion related to what case management really is and how it works. It is difficult to understand the model without understanding the role, and vice versa. Once the various adaptations of the role and the model are mixed and matched, things really get complicated. The best way to understand the role and the model is to think of them in terms of what the goals of case management are (Box 1.4), and the drivers behind the application of case management over time (Box 1.5).

Regardless of the setting in which case management is implemented, there are goals that can be identified that are consistent across the healthcare continuum (see Box 1.4). Whether it is a hospital, a nursing home, or a community care setting, the model attempts to address both cost and quality issues and to deliver care in ways that result in the most positive patient and organizational outcomes.

The case manager accomplishes these goals by performing a number of complex role functions. These may include but are not limited to care coordination, facilitation, education, advocacy, transitional planning, discharge planning, utilization management, avoidable delay management, resource management, and outcomes management. These functions remain consistent across care settings and levels of care along the continuum.

1.4.5. Case Management as an Outcomes Model

Case management is not only a process model but also an outcomes model in that it provides a prospective

Box 1.4 Goals of Case Management and the Case Manager's Role Functions

Overall Goals

1. Manage cost, quality, and safety
2. Achieve positive patient and organizational outcomes
3. Enhance timely access to healthcare services and resources

Role Functions

1. Care coordination
2. Facilitation
3. Avoidable delay management
4. Education
5. Advocacy
6. Brokerage of community services and resources
7. Transitional/discharge planning
8. Resource and utilization management
9. Outcomes management

Goals and Role Function

Goals and role functions are usually driven by the functional areas a case management program consists of. Often case management programs include some or all the following:

1. Clinical care management (facilitation and coordination of care)
2. Utilization review and management (including allocation of resources, certification/authorization for care and services)
3. Transitional/discharge planning and handoffs
4. Access management and patient flow
5. Outcomes evaluation and management
6. Variance management (e.g., delays in care, ommissions or overuse of unnecessary resources)
7. Clinical documentation improvement

approach for planning the ways in which care will be provided, the steps in the care process, and the desired outcomes of care. In other words, for each step in the process, there is also an expected outcome that can be predetermined and managed. All steps in the process are designed to move the patient toward the desired outcome.

1.5. CHANGES IN REIMBURSEMENT: THE DRIVING FORCE BEHIND CASE MANAGEMENT

It was not until the 1980s that case management truly came into its own. Before 1983, healthcare costs were not of major concern to the healthcare provider. Because most healthcare reimbursement was based on a fee-for-service (FFS) structure, there were no financial incentives to reduce costs. In fact, because the use of resources was financially rewarded by the system, overuse abounded. This overuse and misuse of healthcare resources, particularly those in the acute care setting, resulted in spiraling costs for the consumers of care (Box 1.6). Concurrently, the costs of pharmaceuticals, radiology, and supplies continued to escalate with minimal management of those costs. In the 1990s and beyond, healthcare in the United States is a trillion-dollar business.

Box 1.5 Evolutionary Process of Case Management Application

1. 1920—Psychiatry and social work; outpatient settings
2. 1930—Public health nursing
3. 1950—Behavioral health across the continuum
4. 1985—Acute care
5. 1990—All healthcare settings
6. 2010—Healthcare reform increasing the role of community-based care (patient centered medical home and accountable care organizations)

It is therefore no great surprise that the healthcare system eventually broke down. Consumers and third-party payers were no longer willing to pay these high costs when the quality of the services they were receiving was barely keeping pace. In fact, it appeared to most consumers of healthcare that the quality of the services they were receiving was diminishing and that the value of the care was reduced. The costs were rising while the value was subsiding.

The mid-1980s were witness to a flurry of activities all designed to figure out how to improve the quality of healthcare while reducing the cost. The expected result was an increase in value. On the payer side, we first saw the introduction of the prospective payment sys-

Box 1.6 Forces Driving the Move Toward Case Management

1. 1970s—Escalating healthcare costs
2. 1980s—Prospective payment system in acute care settings
3. 1990s—Managed care infiltration
4. 2000s—Prospective payment system in home care, outpatient care, rehabilitation services, and long-term care
5. 2010s—Healthcare reform and value-based purchasing

tem with the diagnosis-related groups (DRGs) as the reimbursement scheme. Shortly after that, the western United States saw an increase in the use of managed care and health maintenance organizations (HMOs). DRGs and managed care are discussed in Chapter 2. Employers saw the use of HMOs as a way to reduce the cost of providing healthcare insurance to their employees. Several states, including Minnesota, California, Arizona, and Tennessee, have since adopted broad-based managed care programs. By the turn of the twenty-first century, managed care reimbursement systems had permeated throughout the United States.

Unfortunately, many of the efforts resulting in changes in reimbursement and the introduction of managed care were perceived solely as cost cutting. Although much lip service was given to the notion of quality, effective and consistent outcome measures, as well as measures of quality of care, were lacking. What did exist were financial parameters that guided outcomes evaluation, such as length of stay and cost per case. Within 3–5 years organizations began to recognize the need to incorporate quality into the agenda. Much of this came out of healthcare organizations themselves. Two major quality improvement models drove the quality initiatives. The first was total quality management and the use of continuous quality improvement (CQI) methods. The second was case management. Ultimately, both of these concepts became the framework for redesign efforts and patient-focused care.

1.6. THE COST/QUALITY RATIO

CQI has been linked in philosophy and practice to case management. CQI methods are used to drive case management processes and to monitor outcomes (Cesta, 1993). Other methods used to improve quality of care now include Six Sigma™ as a commonly used framework for quality improvement (Pande, Neuman, & Cavanaugh, 2000). Case management is now recognized as a system for delivering care that coordinates interdisciplinary care services, plans care, identifies expected outcomes, and helps facilitate the patient and family toward those expected outcomes. The case manager is responsible for ensuring that the patient's needs are being met and that care is being provided in the most cost-effective setting or level of care.

CQI and/or Six Sigma can address both system and practice issues, looking for opportunities for improvement that will result in reduced cost and improved quality of care. Without addressing and improving these processes, case management as a delivery system will not be effective. When implemented, case management affects the patient population served as well as every part of the organization, every discipline, and every department. Therefore it is sometimes necessary to correct existing systems or interdisciplinary problems before the model can be successfully implemented. CQI can then be applied to measure and continuously monitor the progress and outcomes of the model.

1.7. NURSING CASE MANAGEMENT

Nursing case management evolved as a hospital-based care delivery system in 1985. Before that time there had been a number of other nursing care delivery systems, including functional, team, and primary nursing. It has been said that nursing case management incorporates elements of both team and primary nursing. In team nursing, a nurse team leader directs the care being provided by all the members of the nursing team, including RNs, licensed practical nurses, and nurse aides. The team leader generally does not provide direct patient care but directs the care being provided by the members of the team.

1.7.1. Move from Team to Primary Nursing

In the 1970s team nursing evolved to primary nursing. In primary nursing, the RN is responsible for providing all aspects of care to an assigned group of patients. With the assistance of a nurse aide, the RN carries out all direct and indirect nursing functions for the patient. One of the goals of primary nursing is the reduction in fragmentation of nursing care. The primary nurse provides all facets of care to the patient but works independently. It was anticipated that primary nursing would enhance the professionalism of nursing by upgrading the level of autonomy and independent practice.

1.7.2. Breakdown of Primary Nursing

With the advent of the prospective payment system in 1983, primary nursing became increasingly difficult to implement. Although it provided a structure for the RN to function autonomously and independently, it did not address the cost/quality issues affecting the healthcare delivery system in the 1980s. As lengths of stay began to shorten, care activities had to be accelerated. At the same time the nursing profession began to experience a nursing shortage, and various strategies were put into place to recruit and retain nurses. One of these was flexible (flex) time, including 12-hour shifts. Twelve-hour shifts provided the RN with more flexibility in terms of the work schedule. This might mean more time to spend raising a family, or it might mean time to return to school. In any case, nurses working three

days a week, combined with accelerated hospital stays, resulted in increasing difficulty in maintaining a primary nursing model. Continuity of patient care was all but destroyed as nurses worked only three days a week. With shortened lengths of stay, it was possible that the nurse who began caring for the patient on admission might not be the same nurse caring for the patient on discharge. It was very expensive to staff nursing units to the extent necessary to maintain as much continuity as possible. In addition to the cost of personnel, primary nursing was not designed to manage care in shorter timeframes or place an emphasis on the management of resources. Care was not outcome focused, and the healthcare providers were fragmented.

1.7.3. Early Hospital-Based Case Management

Two hospitals attempted to respond to the changing times by addressing the changes in healthcare reimbursement, shortened lengths of stay, and dwindling hospital resources. Carondelet St. Mary's Hospital in Tucson, Arizona, and New England Medical Center in Boston, Massachusetts, were the first to recognize the need to redesign their nursing departments. Each introduced nursing case management models that incorporated elements of both team and primary nursing within a context of controlled resources and shortened lengths of stay. The early case management models were structured on using hospital-based nurse case managers to monitor the patient's progress toward discharge.

Carondelet's model was initially designed as an acute care case management model. The job title "Professional Nurse Case Manager" described an RN with the minimum educational preparation of a bachelor's degree. The case manager assumed responsibility for managing patients toward expected outcomes along a continuum of care. Carondelet collected data for the first 4 years after implementation of the model and found that quality and cost were both improved. Job satisfaction improved for nurses, and their job stress decreased. In addition, patient satisfaction increased (Ethridge, 1991).

Perhaps the most compelling finding was that some patients with chronic illnesses were not hospitalized at all (Ethridge & Lamb, 1989). Those who were admitted had lower acuity levels. They were immediately linked to the healthcare system so that the length of stay at the beginning of the hospitalization was decreased. This resulted in lower costs for the hospital (Ethridge, 1991).

These findings resulted in the development of the first nursing HMO. The initial program, began in 1989, focused on case-managing patients from a senior-care HMO. The nurse case manager screened all patients admitted under the Senior Plan contract. The assessment included determining the necessary nursing services before discharge, monitoring of any community services being provided, and ensuring a continuation of care in the community if necessary. Because the fees were capitated, the case manager could match the patient's needs with the appropriate services.

New England Medical Center Hospitals (NEMCH) in Boston, Massachusetts, used RNs in positions of senior staff nurses to pilot the case manager role. The case managers carried a core group of patients for whom they provided direct patient care. They worked closely with physicians, social workers, utilization managers, and discharge planners. The core of the care delivery system was that outcomes should drive the care process. Several versions of critical pathways were developed for planning, managing, documenting, and evaluating patient care. During those early years the "tools of the trade" moved more and more toward care management tools that structured the care process and outcomes and were more interdisciplinary (Zander, 1996).

Both models were deemed successes by their organizations. Across the country other hospitals began turning to these two role models for ideas, direction, and support. This was a watershed moment in healthcare delivery. Unprecedented numbers of healthcare organizations began to think about or implement case management. Its position in the healthcare arena was secured.

Although case management initially addressed the changes necessary for organizations to survive prospective payment, it was even more effective in its management of cases under a managed care system. In both reimbursement systems, patient care must be managed and controlled, with a tight rein on the use of resources, the length of stay, and continuing care needs.

The majority of the models of the 1980s did little in terms of changing the role functions of the other members of the healthcare team. Whereas nursing provided the driving force for the movement toward hospital-based case management, the other disciplines were slower in recognizing the value of such a system. Additionally, serious downsizing was only just beginning in the industry. Corporate America had already begun its massive layoffs and downsizing initiatives. Thousands of people lost their jobs. Healthcare had not yet begun to feel the economic pinch as it was being felt in other businesses; therefore the incentive for merging and downsizing departments was not yet there.

Shortly after these early models, case management began to mature as more and more hospitals began to implement case management models. One could see a direct correlation between the degree of managed care infiltration and the use of case management. In nursing case management, the nurse essentially functions as the leader of the team, similar to the team nursing approach. The difference was that the team did not consist of nurses only. Now the team was an interdisciplinary one, and each healthcare provider had a say in terms of how a patient's care would be delivered and monitored.

Shortly after this popularity of the nursing case management models, other disciplines caught on and began to pursue the design and implementation of case management systems. This increased buy-in from other disciplines resulted in an outbreak of these models throughout the country, leading to the birth of interdisciplinary approaches in the design; hence dropping "nursing" from the label to better reflect the models because they no longer were nursing in nature. Today, case management departments most commonly report to the chief operations or medical officers of an organization rather than to nursing services. This shift in reporting structure has resulted in giving case management departments more credence and power in an organization.

1.8. EARLY COMMUNITY-BASED CASE MANAGEMENT

Case management, although more commonly thought of as an acute or hospital-based model, has its roots in the community. Long before hospitals were considered the center of the healthcare universe, case management was being used for a variety of purposes and to meet the needs of diverse populations of patients.

Case management finds its roots in public health nursing, social work, and behavioral health. We can find evidence of case management in the 1860s, where case management techniques were used in the settlement houses occupied by immigrants and the poor. "Patient care records" consisted of cards that catalogued the individual's and family's needs and/or follow-up needs, all aimed at ensuring that the patient/family received the services that they needed and that additional services would be provided as necessary (Tahan, 1998).

Another example of a case management application, also in the 1860s, was the first Board of Charities established in Massachusetts. Aimed toward the sick and the poor, public human services were coordinated with a primary goal of conserving public funds (Tahan, 1998). Even in the 1860s, cost containment was a concern as it related to the distribution of public funds to the poor. Social workers were the health professionals responsible for managing these processes.

In the early 1900s case management strategies were implemented by public health nurses at the Yale University School of Nursing. A collaborative effort was established between a clergyman and the superintendent of the school. The clergyman described the nurse's role and the requirements he sought in the following ways:

1. Knowledge and expertise
2. Communication skills
3. Cost containment
4. Collaboration with physicians
5. Appropriate allocation of resources
6. Responsibility for overall care of the patient and family
7. Provision of emotional and psychosocial support and the assurance of a dignified and peaceful death
8. Coordination and management of care
9. Facilitation of the delivery of patient care activities
10. Obtaining funds for special programs (Tahan, 1998)

Review a contemporary case manager's job description and you are likely to find the superintendent's expected role functions and requirements there.

Around the same time that public health nursing was embracing case management concepts and techniques, the field of social work was using care coordination techniques with a focus on linking patients and families to available resources. Social work began to emerge as the discipline focused on linking or brokering healthcare services for individuals. Conversely, the early nursing case management models included both coordination and care delivery functions. In many ways these differences remain in the approaches taken by both disciplines in the delivery of contemporary case management.

The 1950s was the decade in which behavioral health workers began to use case management tools and strategies. Targeted were World War II veterans who presented mental and emotional problems in addition to physical disabilities. *Continuum of care* was labeled for the first time, and in this context it related to the myriad of community health services these individuals required and accessed. Behavioral health case managers accessed, coordinated, and ensured that service needs were met on a continuous basis. These strategies can still be found today in many behavioral health models of care delivery.

1.8.1. The 1970s and 1980s

During the 1970s and 1980s the federal government provided funding to support the development of several demonstration projects focused on long-term care. Legislation was enacted at the state and federal levels to incorporate these projects into strategic planning policies. Reimbursement was established through Medicare and Medicaid waivers. Some of the better known projects included the Triage Program in Connecticut, the Wisconsin Community Care Organization, the On Look Project in San Francisco, the New York City Home Care Project, and the Long-Term Care Channeling Demonstration Project in San Francisco (Cohen & Cesta, 1994).

By the late 1980s, community-based case management programs were emerging in many parts of the country as a mechanism for managing patients and resources in capitated environments. One important example is the Carondelet Saint Mary's Model in Tucson, Arizona (Cohen & Cesta, 2001). These emerging and contemporary models returned case managed to its original roots, the community. Case management had now completed a circle that took over 100 years to circumnavigate.

1.8.2. The 1990s

As a result of the re-emergence of community-based case management, the CMS, formerly the Health Care Financing Administration (HCFA), funded five demonstration projects that used registered professional nurses in the role of community case managers to coordinate care for the Medicare beneficiaries. These projects were called *community nursing centers*, and they are as follows:

1. The Carle Clinic at the Carle Organization in Urbana, Illinois (Schraeder & Britt, 1997)
2. A School-Based Health Center at The University of Rochester in Rochester, New York (Walker & Chiverton, 1997)
3. The Silver Spring Community Nursing Center at the University of Wisconsin, Milwaukee (Lundeen, 1997)
4. The University Community Health Services Group Practice at Vanderbilt University in Nashville, Tennessee (Spitzer, 1997)
5. The Carondelet Health Care Corporation at Carondelet St. Mary's Hospital in Tucson, Arizona (Ethridge, 1997)

A special feature of these centers is that they relied on nurses as the main providers of care with physicians in consultative roles. These centers demonstrated the ability to affect both the process and outcomes of care. Examples of the services provided or arranged for and coordinated by the nurse case managers were health risk assessments; authorization, coordination, evaluation, and payment of services; services such as home care, transportation, respite care, and home-delivered meals; preventive and psychiatric mental health; health promotion activities such as exercise, nutrition, and lifestyle changes; durable medical equipment; and medical or minor surgical care.

1.9. HISTORY OF EVIDENCE-BASED GUIDELINES

It has been almost two decades since the introduction of case management plans as a method of controlling cost and quality in healthcare. First known as critical pathways, these tools have grown in scope and sophistication over the years (Box 1.7). Critical pathways were originally designed and implemented by nursing departments as a paper-and-pencil system for outlining the course of events for treating patients in a particular DRG for each day of hospitalization (Zander, 1991; Nelson, 1994; Cohen & Cesta, 1997).

In a broader fashion, critical pathways outlined the key or critical steps in the treatment of the DRG in a one-page summary. Because DRGs are broad groupings or classifications of similar types of patients, the critical pathway also had to be broad and nonspecific in nature (Edelstein & Cesta, 1993). The original critical pathways were mainly focused on nursing interventions and tasks. The daily interventions such as blood work or other diagnostics and therapeutics were outlined generically and were applicable to a host of different patient types. Because of the generic nature of the plans, they did little to control the use of resources, types of medications, route of administration, or other factors related to cost and quality. Although they did suggest the appropriate number of hospital days to allocate to the DRG, they did little beyond that to control the kinds of product resources applied to the particular broad grouping of patients.

Box 1.7 Elements of an Effective Case Management Plan

1. Interdisciplinary in nature
2. Outcomes based
3. Clinically specific
4. Care provider documentation included
5. Flexible enough to meet individual patient's care needs

1.10. CASE MANAGEMENT PLANS TODAY

Critical pathways were a good first attempt at providing a framework for controlling cost and quality within the prospective payment system of the acute care setting. Subsequent adaptations of the critical pathway concept began to use more specific and direct clinical content in a multidisciplinary format and multiple settings or levels of care. These more sophisticated case management plans are called multidisciplinary action plans (MAPs), clinical guidelines, practice guidelines, practice parameters, care maps, and so on. Today's case management plans are clinically specific, incorporate other disciplines, are outcome oriented, and may include care provider documentation. In addition to being more clinically specific, these plans are focused around specific clinical case types rather than DRGs. Thus the content applies to the clinical issue being planned out. This may be a medical problem, surgical procedure, or workup plan (Hampton, 1993; Tahan & Cesta, 1994; Cohen & Cesta, 1997). Chapter 12 contains more detailed information on the various adaptations of the current "tools of the trade" in case management. Appendices 1 and 2 present examples of several different types of case management plans.

1.10.1. Benchmarking

Evolutionary changes involved much more specificity in terms of the content of the case management plan. Benchmarking is used as a strategy for understanding internal processes and performance levels; it provides a basis for understanding where the performance gaps are. It brings the best ideas that identify opportunities and helps the organization to rally around a consensus. In addition, it results in the implementation of better-quality products and services (Czarnecki, 1994).

The clinical content for the case management plans should be based on benchmarks such as those established by the following:

- Professional societies
- Professional journals
- Health systems and hospital corporations
- Texts and manuals
- National databases

One or more of these benchmarks can be used to develop any one plan. In this way much of the subjectivity is taken out of the plan of care and instead the care is based on sound judgment, expert opinion, and research outcomes. With this step in the evolutionary process, the plans became much more clinically directive and began to provide a framework for controlling resource application for specific case types.

1.11. MULTIDISCIPLINARY CARE PLANNING

The next step in the evolutionary process was the introduction of plans that had a more multi-disciplinary focus and that incorporated the plan of care for all disciplines represented (Goode & Blegan, 1993; Adler, Bryk, & Cesta, 1995). The final step was the addition of expected outcomes of care that applied to the specific interventions on the plan. In other words, for each intervention there was an expected outcome for the patient to achieve before the patient could move on to the next phase of care (Sperry & Birdsall, 1994). Box 1.8 presents an example of expected outcomes.

1.12. CHOOSING A CASE MANAGEMENT TOOL

A variety of case management tools are available today. The tool chosen by any organization should be based on that organization's needs and goals. Some issues to be addressed during the design and implementation process are summarized in Case Manager's Tip 1.1 and are described in more detail in the following paragraphs.

1.12.1. Format: Critical Pathway Versus Multidisciplinary Action Plan

A critical pathway is generally formatted as a one-

Box 1.8 Expected Outcomes as They Might Appear on a Multidisciplinary Action Plan for Community-Acquired Pneumonia

Intermediate Outcomes (Also Known as Milestones or Trigger Points)

Convert from intravenous to oral antibiotics when the patient:

1. Has two consecutive oral temperatures of less than 100.4°F obtained at least 8 hours apart in the absence of antipyretics
2. Shows a decrease in leukocytosis to less than 12,000
3. Exhibits improved pulmonary signs/symptoms
4. Is able to tolerate oral medications

Discharge Outcomes

In less severe pneumonia, discharging the patient from the hospital may occur simultaneously or up to 24 hours after switch to oral antibiotics, providing there is no deterioration or other reason for continued hospitalization.

CASE MANAGER'S TIP 1.1

Choosing a Case Management Tool

When choosing a case management tool, be sure to address the following issues during the design and implementation process:

1. Format: critical pathway versus MAP
2. Utility as a documentation system
3. Inclusion as a permanent part of the medical record
4. Interdisciplinary nature
5. Legal issues related to care providers' use of the tool
6. Fulfillment of the standards and requirements of accreditation (e.g., The Joint Commission [TJC]) and regulatory agencies (CMS)

page summary of the tasks to be accomplished for a specific diagnosis or DRG. It does not include outcomes and is usually not used as a documentation tool. In addition, it is customarily not a part of the patient's medical record. MAPs, however, are more comprehensive in nature, are usually a part of the patient's permanent record, include outcomes, and are interdisciplinary.

1.12.2. Utility as a Documentation System for Nurses and Other Healthcare Providers

The MAP is intended to be used as a documentation tool. This is most often accomplished by using the MAP in conjunction with a documentation-by-exception system, whereby the expected patient outcomes are prospectively identified and then charted against the timeframes established. To date the majority of such documentation systems incorporate only nursing documentation. Some organizations have successfully included other disciplines such as social work, nutrition, and physical and occupational therapy. The format can be adjusted to include other disciplines such as physicians by including more narrative note space within the document and medical orders as a preprinted order set.

1.12.3. Inclusion as a Permanent Part of the Medical Record

If the MAP is to be used as a documentation tool, then it clearly must be included as part of the permanent medical record. Some organizations, out of fear of legal liability, opt not to include the MAP as a part of the record. It is believed that this reduces their liability. In reality, if the plan is the standard of care for the organization, then the organization is responsible for producing the standard should a legal issue arise (Hirshfeld, 1993); therefore it is discoverable and admissible in court regardless of whether it is a part of the medical record. If the MAP is used to guide the clinical care of a particular patient the hospital is being sued for, the court may demand that the MAP be made available. If the physician did indeed follow the MAP, then it will afford legal protection to the physician and the organization.

In any case, some organizations may choose to test the MAP outside the medical record first before sanctioning it. In situations such as this in which the MAP has not been approved by the hospital, patient consent may be necessary. Otherwise the use of two different standards of care cannot be justified.

Including the MAP as part of the medical record lends the medical record more weight and credibility than not including it. Including the MAP clearly gives the message that the organization stands behind it as the standard of care and believes that the MAP represents state-of-the-art care.

1.12.4. Interdisciplinary Nature, Incorporating All Disciplines in the Care Process, and Expected Outcomes

Early case management plans did not include all disciplines but had a heavy nursing focus and emphasis. As case management has evolved and matured, case management plans have become more multidisciplinary. Although it may be more difficult to include the documentation of all care providers, it should be easier to include all disciplines in the actual plan itself. Expected outcomes for each discipline can be prospectively identified and incorporated. The biggest advantage to creating an interdisciplinary plan is that it reduces duplication and fragmentation and provides proof of an integrated plan of care for accrediting and regulatory agencies. Opportunities to reduce redundancy become more obvious when the plans for each discipline can be reviewed and compared. This approach also enhances the use of existing personnel by ensuring that all are carrying out the care activities most appropriate to their disciplines. Areas in which this becomes obvious include patient education and discharge planning, where there is greater likelihood that duplication of effort may take place.

Because quality and length of stay are affected by the efforts of each and every member of the healthcare team, it only makes sense to include all of them in the planning process.

1.12.5. Legal Issues for Physicians, Nurses, and Other Providers

Many healthcare providers may feel anxiety related to the use of MAPs and other case management plans. This may be due to a lack of understanding related to the legal issues concerning these kinds of tools. Legal issues should be carefully discussed with the organization's risk management department after a thorough review of the literature is completed. Each organization must weigh the legal pros and cons and draw its own conclusions as to whether this is a concept that the physicians can adopt and embrace. Another strategy to reduce legal risk and curtail providers' hesitancy to using the MAPs is to review the stance taken by the various professional societies and associations, such as the American Medical Association and the American Nurses Association. Almost all professional societies are in favor of using MAPs in some form or another.

1.12.6. Fulfillment of The Joint Commission Requirements for Care Planning, Patient Teaching, and Discharge Planning

The standards for TJCs focus on the incorporation of all disciplines into the plan of care for those tasks that are interdisciplinary in nature (www.jointcommission.org). The MAP, by nature of its format and philosophy, is designed to ensure that all disciplines are represented and integrated in the plan.

1.13. PHYSICIAN SUPPORT

Physician support is a key component in the success or failure of any case management plan, no matter what format it takes. Although these plans were once feared as legally dangerous, physicians are beginning to realize some of their legal benefits. Conceptually, case management plans can meet physician, hospital, and patient needs in a number of ways.

1.13.1. Aid to Shortening Length of Stay

To maintain financial viability, acute care settings must shorten the number of inpatient hospital days. Whether the reimbursement system is negotiated managed care or the prospective payment system, length of stay can translate to financial success or failure for any hospital in today's healthcare environment.

1.13.2. Selling Tool for Managed Care/HMOs

An ability to demonstrate systems that control cost and quality is essential to any forward-thinking healthcare organization in the 2000s and beyond. Case management plans that are prospective and outcome oriented and outline both the appropriate length of stay and expected outcomes and the appropriate use of resources for a particular case type provide a structure for controlling cost and quality. These plans can be shared with managed care organizations before admission to demonstrate how the hospital manages a particular case type, or they can be used as a concurrent review tool to justify the length of stay and resource allocation.

1.13.3. Means of Legal Protection

Practice guidelines and case management plans can protect physicians from a risk liability perspective in that they outline what is appropriate to do, as well as what is not appropriate to do. They provide for a plan of care that is supported by the organization in which they work (West, 1994).

1.13.4. Aid to Regulatory Agency Compliance

For TJC or other regulatory bodies, case management plans are recognized as an excellent vehicle for integration of care and maintaining and improving quality. By outlining the expected clinical outcomes and documenting deviations from those outcomes, the organization can identify opportunities for clinical process improvements (www.jointcommission.org).

1.13.5. Means of Providing a Competitive Edge

Clearly the organizations that maintain market-share advantage will be the ones that will remain competitive in the managed care environment. If "covered lives" is the name of the game, a competitive edge will lie with those organizations that have captured the greatest market share. This means that they will have negotiated managed care contracts that provide for maximum reimbursement and that have large patient populations.

1.13.6. Source of Practice Parameters

A variety of respected organizations have developed practice guidelines (see Section 1.10.1). Physicians, nurses, and other providers can refer to their own specialty organizations regarding state-of-the-art guidelines (Holzer, 1990).

1.14. BENEFITS OF CASE MANAGEMENT

Internally there are many reasons why case manage-

CASE MANAGER'S TIP 1.2

Benefits of Case Management Plans

When soliciting support for case management plans, focus on the ways in which they can help to ensure the healthcare organization's success. Case management plans help do the following:

1. Simplify and integrate care
2. Improve reimbursement
3. Objectify decision making
4. Contain cost
5. Prioritize resources
6. Ensure quality outcomes

ment plans spell success or failure (see Case Manager's Tip 1.2).

1.14.1. Simplify Care

Case management plans provide a systematic format for all disciplines to use in the treatment of specific case types. All disciplines involved in the care of the specific group of patients represented are included in one interdisciplinary plan of care. In some cases, documentation is also included so that the entire course of events is seen in one documentation tool (Adler et al., 1995).

1.14.2. Improve Reimbursement

Because documentation is enhanced, there is greater opportunity for the medical record to be coded properly and for managed care organizations to authorize needed services. Proper coding and authorizations mean maximization of reimbursement.

1.14.3. Objectify Decision Making

Although a tremendous amount of subjectivity and judgment goes into the art of practicing medicine, there still remains a core of safe and appropriate clinical practice that is based on research and state-of-the-art recommendations. Case management plans provide a vehicle for communicating these clinical recommendations in an objective manner.

1.14.4. Contain Cost

Because case management plans provide a foundation for reducing variability in medical treatment, they serve as a tool for controlling cost. Care needs, both product and personnel, are prospectively determined so that the organization can predict its resource needs and reduce the need for a variety of different brands and types of the same product. This ultimately has an effect on cost. The plans outline the expected length of stay, thereby controlling the number of hospital days and resulting in cost savings to the hospital. Daily resource application is also outlined, which will translate to saved dollars for the organization (Edelstein & Cesta, 1993; Jijon & Jijon-Letort, 1995).

1.14.5. Prioritize Resources

Resource use is closely tied to cost containment. By properly using resources, costs are reduced. Other issues involve the appropriate use of existing resources, both product and personnel. Case management plans can provide a framework for identifying which members of the healthcare team will provide which services. So much of the misutilization and/or overutilization of healthcare resources occurs because of lack of communication between departments and disciplines. Through case management, the work to be done can be allocated to the most appropriate member of the team. Responsibilities are outlined prospectively rather than on a case-by-case basis. This reduces the opportunity for redundancy or for things to fall through the cracks and not be done at all. For example, discharge planning functions can be allocated to the most appropriate care provider, thereby using personnel most appropriately and as early in the process as possible (Tahan & Cesta, 1994).

1.15. INTERDISCIPLINARY TEAM

Case management has provided a structure for healthcare providers to develop teams that are truly interdisciplinary and collaborative. In the past, either various disciplines have controlled the team or the team was composed of only one discipline. For example, "patient care rounds" were generally physician dominated and focused on the medical plan. In team nursing, the team was composed of only nurses. The team leader was a nurse, members of the team were nurses, and so on. Discharge planning rounds were often interdisciplinary but were focused on the patient's discharge plan and social services.

1.16. CHANGE PROCESS

Case management as a delivery model crosses all boundaries within the organization. Therefore it is critical that the members involved in the development of

the team represent all those affected. The roles most closely affiliated with that of the case manager are utilization management, transitional/discharge planning, and home care. During the design process, an interdisciplinary team representing these departments should be brought together to examine current practice and to look for opportunities to redefine role functions within the organization.

Logically the membership should consist of those individuals who have the power and authority to make the necessary changes in the role functions of these departments. During the analysis phase, some disciplines may feel threatened or defensive about their current functions within the organization and may interpret the need to change as a criticism of their current job performance rather than as identifying opportunities to make the organization more productive and efficient.

This period while current processes are analyzed and critiqued may cause some anxiety. How well this group works through the process will greatly depend on the members' interpersonal relationships, their vision, and their ability to collaborate.

Using the techniques of CQI, Six Sigma, and other methods for performance improvement will help to facilitate this process (Cesta, 1993).Quality improvement helps to place everyone on an equal playing field as processes are analyzed and changed (see Chapter 13). The team should first examine current practice by looking at what the various departments and disciplines are currently doing, where there may be overlap or redundancy, and where things may be falling through the cracks. Only then can opportunities for improvement be initiated. One useful tool for this technique is the flow diagram. The flow diagram provides the team with a visual representation of their current practice, where quality barriers may be, and where opportunities for improvement may lie (Figure 1.1).

The social worker and the case manager may be duplicating some discharge planning functions. There may be confusion between them in terms of who is doing what; specific tasks must then be negotiated as they arise. This results in confusion and delays because each episode requires an analysis, a discussion, and a resolution.

This executive-level team essentially designs the case management model after a thorough analysis has taken place. The role functions of each member of the team are clearly outlined and delineated prospectively before going further with the implementation process.

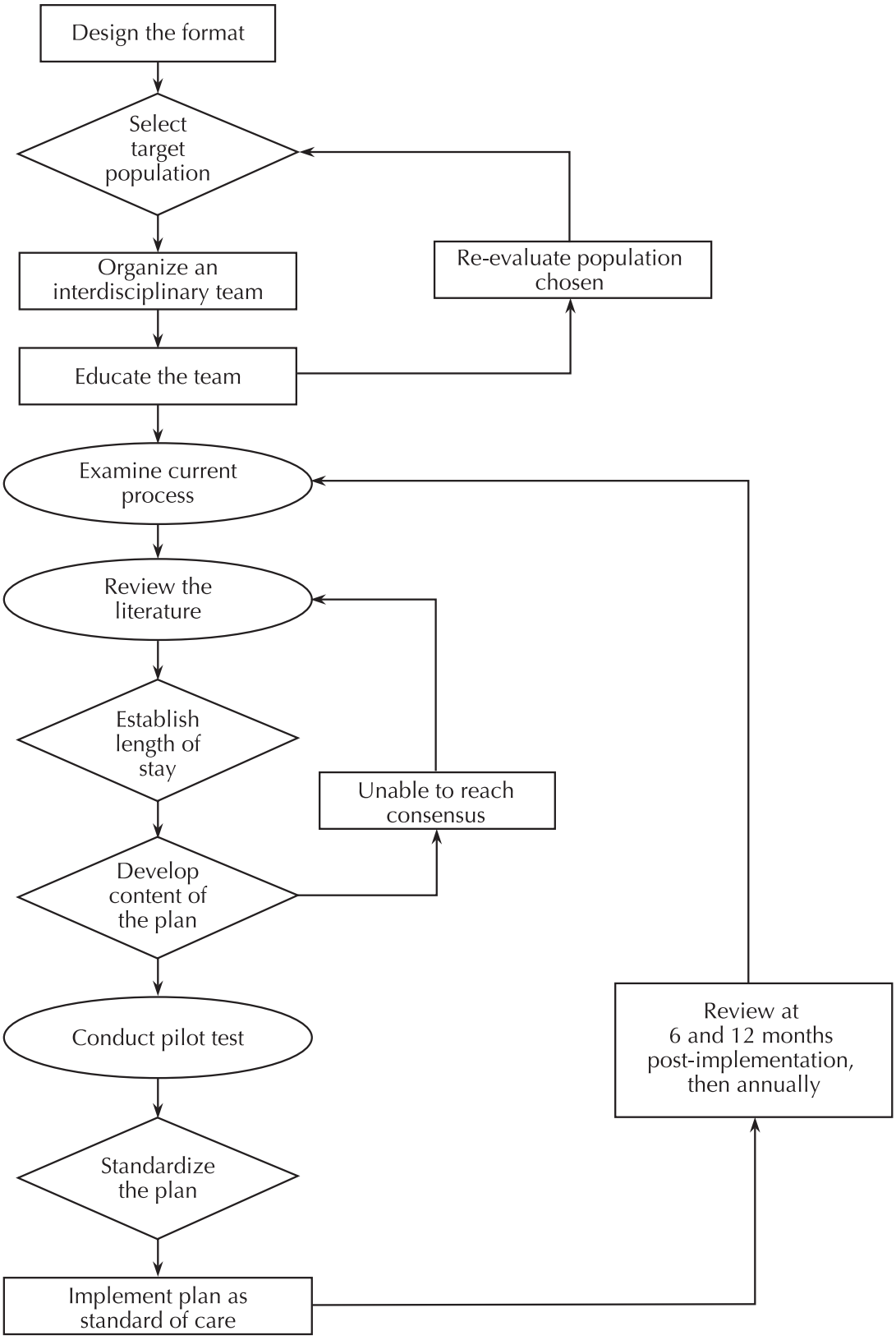
Once these role functions have been determined, the members of the interdisciplinary case management team can be assembled to carry out a number of important functions. The team members are those clinicians and others who are directly involved in the care process. The team first prospectively develops the case management plan. The plan, as discussed in Chapter 12, is collaboratively developed by the team to manage the case as efficiently and cost-effectively as possible. The team also individualizes the plan to the specific patient. Finally, the team implements the plan. The case manager serves as the thread that binds the interdisciplinary team together. The case manager does not lead the team but essentially guides the team and the patient/family toward the achievement of the expected outcomes as identified in the plan.

The members of the team are fluid and depend on the patient's location, clinical problem, and expected long-term needs. Core members of the team should always include the physician, nurse, case manager, social worker, discharge planner, and patient/family. Additional members depend on the picture presented. For example, orthopedic problems warrant the physical therapist's membership on the team; pulmonary problems necessitate the respiratory therapist. For the diabetic or other patient with metabolic problems, the nutritionist should be a member of the team. Clearly, members should be those healthcare providers who have some relevance to the case and who have something to contribute to the interdisciplinary plan of care.

In a time when containing costs has never been more important, a collaborative, interdisciplinary approach is critical to the success of any case management model. Without it, true case management can never take place.

1.17. MANAGED CARE

It has not been uncommon for the terms *case management* and *managed care* to sometimes be used interchangeably. However, there are specific differences between the terms. Although linked philosophically, managed care is a broader term that refers to an organized delivery of services by a select panel of providers (Rehberg, 1996; Kongstvedt, 2001). These services are managed under a prepayment arrangement between a provider of services and a managed care organization. Managed care is a system that provides the generalized structure and focus when managing the use, cost, quality, and effectiveness of healthcare services. HMOs and preferred provider organizations (PPOs) are the two most common types of managed care arrangements. They are essentially health insurance plans that link the



Key:
Box = Activities
Circle = Inputs to/outputs from
Diamond = Decision to be made
Arrow = Direction of flow of activities

Figure 1.1 Flow diagram: Developing a case management plan.

patient to provider services, and their purpose is to improve the efficiency of the healthcare delivery system (Mullahy, 1995, 1998; Kongstvedt, 2001).

Because some physicians' only exposure to case managers has been through a managed care organization, they may see the two as synonymous. They may believe that case managers and case management means managed care. In reality, although case managers can be found in managed care organizations, they are also found in a wide variety of other practice settings (see Chapters 3 and 4).

Case management is a patient care delivery system. Perhaps the most profound difference between case management and managed care is the fact that managed care is a function of a healthcare reimbursement system, whereas case management is a structure for providing care within a managed care reimbursement system. Case management also applies to provider areas that are not reimbursed under managed care. *Managed care* is defined as a means of providing healthcare services within a defined network of providers. These providers are responsible for managing the care in a quality, cost-effective manner (Baldor, 1996).

The initial driving force for case management in the hospital setting was the prospective payment system because of the dwindling reimbursement associated with the DRGs. As managed care continues to proliferate, it has become an even greater force in the movement toward case management. Under full capitation, the incentive is greatest (see Chapter 2). In between full capitation and FFS we now find a wide variety of combinations of insurers, reimbursement systems, and service settings. It may be many more years or more before the dust settles nationally, systems are in place and integrated, and the continuum of care has been defined.

1.18. KEY POINTS

1. Case management originated as a community-based model in the late 1800s and early 1900s.
2. In the 1950s case management emerged in the field of behavioral health, in which the term "continuum of care" was first applied.
3. Case management applications in the 1980s evolved out of changes in the healthcare reimbursement system, specifically the prospective payment system.
4. Healthcare reform has had an effect on the business of case management.
5. Case management can be defined in a number of ways but is essentially a process and outcomes model designed to manage resources and maintain quality of care.
6. Case management tools such as pathways and guidelines can help facilitate the case manager role.
7. It is important for physicians to be part of the design, implementation, and evaluation processes related to case management.
8. Case management uses a team approach and incorporates elements of quality improvement.

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