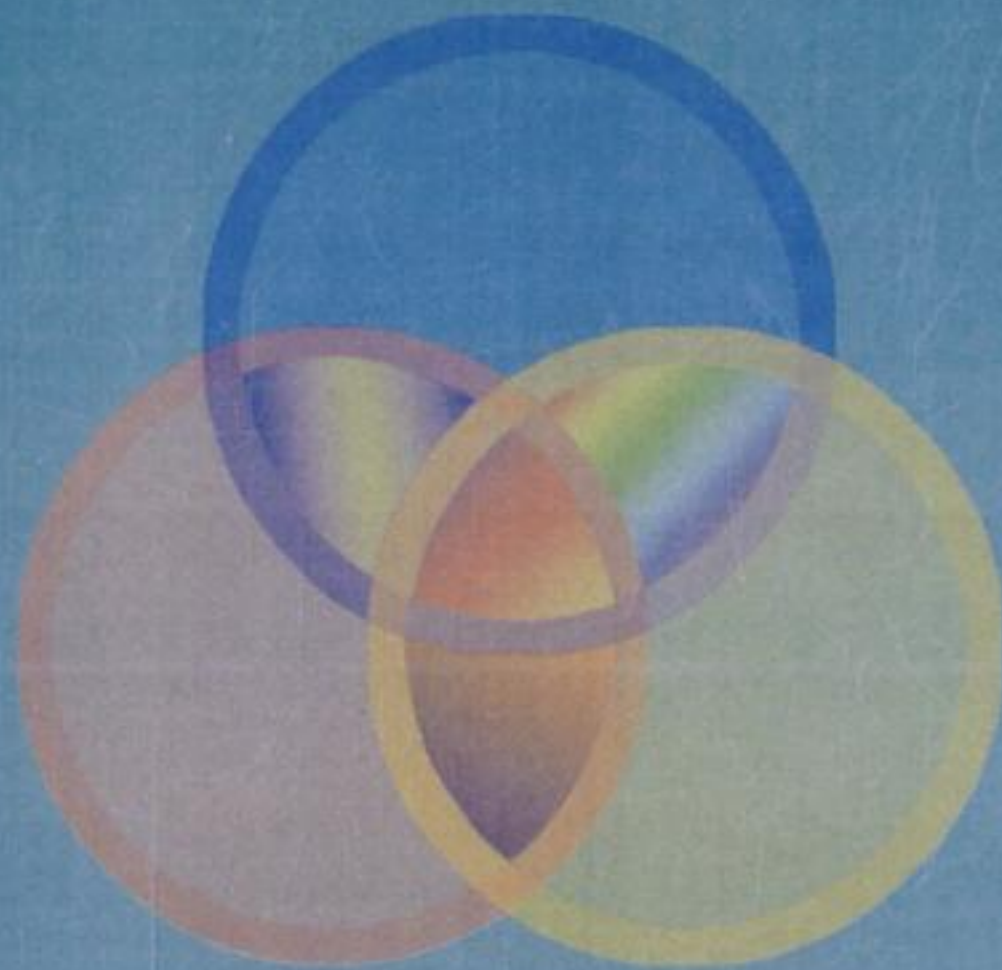


FOURTH EDITION



Nursing Case Management

From Essentials to Advanced
Practice Applications



ELAINE L. COHEN • TONI G. CESTA

Nursing Case Management

From Essentials to Advanced
Practice Applications

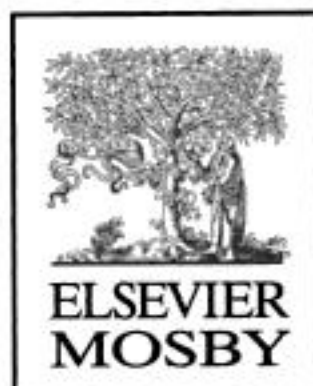
ELAINE L. COHEN, EdD, RN, FAAN

Director of Case Management
Utilization Management, Department of Quality & Outcomes
Associate Professor, School of Nursing
University of Colorado Hospital
University of Colorado
Health Sciences Center
Denver, Colorado

TONI G. CESTA, PhD, RN, FAAN

Vice President
Patient Flow Optimization
North Shore—Long Island Jewish Health System
Great Neck, New York

FOURTH EDITION



**ELSEVIER
MOSBY**

11830 Westline Industrial Drive
St. Louis, Missouri 63146

**NURSING CASE MANAGEMENT: FROM ESSENTIALS TO ADVANCED
PRACTICE APPLICATIONS, FOURTH EDITION**

Copyright © 2005, Elsevier, Inc. All rights reserved.

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any information storage and retrieval system, without permission in writing from the publisher. Permissions may be sought directly from Elsevier's Health Sciences Rights Department in Philadelphia, PA, USA: phone: (+1) 215-238-7869, fax: (+1) 215-238-2239, e-mail: healthpermissions@elsevier.com. You may also complete your request on-line via the Elsevier homepage (<http://www.elsevier.com>), by selecting "Customer Support" and then "Obtaining Permissions."

First Edition 1993. Second Edition 1997. Third Edition 2001.

ISBN-10: 0-323-02765-2

Executive Vice President, Nursing & Health Professions: *Sally Schrefer*
Senior Editor: *Yvonne Alexopoulos*
Developmental Editor: *Danielle M. Frazier*
Publishing Services Manager: *Catherine Albright Jackson*
Senior Project Manager: *Mary Stueck*
Book Design Manager: *Gail Morey Hudson*

Printed in the United States of America

Last digit is the print number: 9 8 7 6 5 4 3 2

Contents

UNIT I EVOLUTION OF CASE MANAGEMENT

- 1** [Evolution of Nursing Case Management in a Changing Health Care System, 3](#)
- 2** Historical Perspective of Nursing Care Delivery Models Within the Hospital Setting, 12
- 3** Historical Development of Case Management, 18

UNIT II CONTEMPORARY MODELS OF CASE MANAGEMENT

- 4** Dimensions of Nursing Case Management, 27
- 5** Two Strategies for Managing Care: Care Management and Case Management, 33
Cathy Michaels and Elaine L. Cohen
- 6** Disease Management: Applying Systems Thinking to Quality Patient Care Delivery, 38
Patricia Hryzak Lind

UNIT III CONTEMPORARY MODELS OF CASE MANAGEMENT: WITHIN-THE-WALLS CASE MANAGEMENT

- 7** Within-the-Walls Case Management: An Acute Care–Based Nursing Case Management Model, 55
with Joanne Woodall
- 8** Collaborative Models of Case Management, 79
Evelyn Koenig
- 9** [Case Management: A Process, Not a Person, 87](#)
Theresa J. Ortiz and Lynn Riippi
- 10** [The University of Colorado Hospital Psychiatric Service Health Case Management Model: An Innovative Approach to Client-Centered Care, 97](#)
Bari K. Platter, Bonnie Cox Young, and Kay Vaughn

UNIT IV**CONTEMPORARY MODELS OF CASE MANAGEMENT: BEYOND-THE-WALLS
CASE MANAGEMENT**

- 11** Beyond-the-Walls Case Management, 125
- 12** Outcomes of Community-Based Nurse Case Management Programs, 129
Jill Scott and Michal Boyd
- 13** Integrated Case Management Model, 141
Mary Lu Gerke
- 14** A Faculty Case Management Practice Based in a College of Nursing, 157
Mary Allen Carey and Margo MacRobert
- 15** A Model of Emergency Department Case Management: Developing Strategies and Outcomes, 166
Carolee Sherer Whitehill

UNIT V**ADDRESSING HEALTH CARE DELIVERY THROUGH CASE MANAGEMENT:
PUBLIC POLICY IMPLICATIONS**

- 16** Patient Demographics Affecting Health Care, 181
- 17** The Business of Health Care and the Prospective Payment System, 188
- 18** Patient Mix and Cost Related to Length of Hospital Stay, 196
- 19** Case Management Legislation: National Attempts to Provide Efficient Health Care, 204
- 20** The Managed Care Market: Nurse Case Management as a Strategy for Success, 210
Tina Gerardi
- 21** Financing Health Care in the United States: Economic and Policy Implications, 219
Richard W. Redman
- 22** Public Policy and Community-Based Case Management: The Nurse-Family Partnership, 227
Patricia Moritz and Ruth A. O'Brien

UNIT VI**THE PLANNING PROCESS: DEVELOPING COLLABORATIVE RELATIONSHIPS**

- 23** Assessing the System and Creating an Environment for Change, 241
- 24** Case Management Education: Preparing for Successful Implementation, 250
- 25** The Competency Outcomes and Performance Assessment Model Applied to Nursing Case Management Systems, 263
Carrie B. Lenburg
- 26** The Role of the Nurse Case Manager, 277
Hussein A. Tahan

*image
not
available*

*image
not
available*

*image
not
available*

Evolution of Nursing Case Management in a Changing Health Care System

Gambar dengan hak cipta

DYNAMICS OF THE CARE CLIMATE

The 1990s marked a decade of major transition in health care as the system shifted from traditional fragmented approaches of health service delivery to greater integration and control brought on by managed care. However, as the 1990s receded and gave way to the 21st century, many of the same issues of access, cost containment, and quality persist. Why these challenges continue is evident by the following:

- Diminished access to health care services for the uninsured population
- Rationed and multitiered distribution of health services
- Mixing of government pricing regulation and market-based competition, resulting in fragmented and cumbersome cost-control initiatives
- Increased control mechanisms for continuous quality improvement and compliance
- Greater demand for concrete, documented information on measurable outcomes at the individual and community levels
- Rising ethical concerns and legal liability resulting in the practice of defensive medicine

*image
not
available*

*image
not
available*

*image
not
available*

providers to predict and manage health risk across a full continuum (Clough, 1996). The Healthy People 2010 Program takes national health initiatives even further by attempting to improve the quality of life for all Americans. Through implementation of national benchmarking standards, Healthy People 2010 will, it is hoped, eliminate the health disparities that exist among racial, ethnic, and economic groups (Healthy People 2010, Department of Health and Human Services, January 2000). These possibilities reflect the complex variations in the practice of case management and its integration into the business of health care.

To establish accountability and guarantee value, nursing case management must embrace the panorama of health care processes and retain a broader, more global political, public, and social systems perspective. Rethinking the future processes and outcomes of nursing case management places this model in sync with evolving population-based care delivery systems. The concomitant effects of such an approach lie not just in one system in which the case manager works but rather in the variety of systems that affect the work of providers and enhance the understanding, role, and practice of the nurse case manager. Subsequent chapters focus on the interdisciplinary integration and coordination elements that are so vital to the successful evolution of case management.

As we thrive in the new millennium, some of the primary system challenges that will continue to influence the provision of health care in general and nursing case management specifically are the growth and consequences of managed care; caring for the population with long-term and chronic illnesses; attending to the uninsured; increased technology, practice, quality, and outcome issues; and consumer service and empowerment—subjects that are covered in later chapters.

PRESERVING THE PAST AND VISIONING THE FUTURE

What Is Nursing Case Management?

Understanding the development of nursing case management as a model is critical to evaluating how it is evolving to meet the needs of the future. Nursing case management, which began as a community-based model in the early 1900s and was adapted for acute care in the mid-1980s, is considered an outgrowth of primary nursing and allows for quality outcomes-focused care while containing costs. This approach to managing the delivery of health care has emerged as a professional practice model that increases nurse involvement in decisions regarding standards of practice and integrates the cost and quality components of nursing services (Zander, 1985). The historical manifestations of nursing case management hold true to present-day practice in that this model provides outcome-oriented patient care within an appropriate length of stay, uses appropriate resources based on specific case types, promotes the integration and coordination of clinical services, monitors the use of patient care resources, supports collaborative practice and continuity of care, and enhances patient and provider satisfaction (Ethridge & Lamb, 1989; Henderson & Wallack, 1987; Stetler, 1987; Zander, 1987, 1988a).

The practice of case management itself can vary from one practice setting to another, with its identifying characteristics dependent on the discipline that uses it, the personnel and staff mix that is used, and the setting in which the model is implemented. Nursing case management, however, is a collaborative approach that focuses on the coordination, integration, and direct delivery of patient services and places internal controls on the resources used for care. Such management emphasizes early assessment and intervention, comprehensive care planning, and inclusive service system referrals.

Several health care settings have adopted unique methods of monitoring patient care activity and resource distribution, such as *critical paths* (a description of patient care requirements in outline form),

*image
not
available*

*image
not
available*

*image
not
available*

- Smith, T., & Brooks, A.M. (1999). Redefining quality: Designing new partnerships for consumer and provider. In E. Cohen & V. De Back (Eds.), *The outcomes mandate: Case management in health care today* (pp. 198-206). St. Louis: Mosby, Inc.
- Stetler, C.B. (1987). The case manager's role: A preliminary evaluation. *Definition*, 2(3), 1-4.
- Taylor, C., & Barnet, R. (1999). The ethics of case management: The quality/cost conundrum. In E. Cohen & V. De Back (Eds.), *The outcomes mandate: Case management in health care today* (p. 30). St. Louis: Mosby, Inc.
- Zander, K. (1985). Second generation primary nursing: A new agenda. *Journal of Nursing Administration*, 15(3), 18-24.
- Zander, K. (1987). Nursing case management: A classic. *Definition*, 2(2), 1-3.
- Zander, K. (1988a). Managed care within acute care settings: Design and implementation via nursing case management. *Health Care Supervisor*, 6(2), 24-43.
- Zander, K. (1988b). Nursing case management: Strategic management of cost and quality outcomes. *Journal of Nursing Administration*, 18(5), 23-30.

*image
not
available*

*image
not
available*

*image
not
available*

Integrated Competencies of Nurses Model (ICON)

ICON models I and II are examples of the earliest alternate care delivery approaches that blend the professional and educational competency levels of staff with the health care needs and requirements of patients (Rotkovich, 1986). The nursing care responsibilities in these models, which were set up as demonstration projects, are differentiated on the basis of the nurse's educational preparation. Head nurses are required to have a master's degree and are responsible for the management and distribution of personnel and resources and overall quality of care delivered on the unit. Nurses with baccalaureate degrees are accountable for the assessment, planning, and evaluation activities of the nursing process. Nurses with associate degrees complement the professional nurse in patient care and carry out nursing decisions. In the ICON I model, licensed practical nurses (LPNs), nurses with diplomas, and nursing assistants are excluded from the staffing complement.

Although ICON I was considered the nursing care delivery system for the future, another model, ICON II, had been implemented and ran concurrently to help LPNs and nurses with diplomas or associate degrees make the transition into their respective practice roles (Rotkovich & Smith, 1987). The goal of this model was to assist through in-service programs, continual education, and clinical preceptors the grandfathering of the associate degree and diploma nurses into the professional nurse's role and the LPNs into the associate nurse's role. This objective is in line with the profession's broader goal of achieving two entry levels of nursing practice.

Cost-effectiveness, quality, and job satisfaction variables were measured and evaluated on an ongoing basis. No data have been published relating the effects of staff mix and competency levels of nursing staff on the productivity and quality of patient care using the ICON I and II models. Information on nursing personnel satisfaction and retention is also missing.

Partners in Practice

The *partners-in-practice system*, defined by Manthey (1989) as a progression from primary nursing, is a partnership established between an experienced senior registered nurse and an individual who supports the nurse as a technical assistant. The technical assistant is assigned to the nurse, not to a caseload of patients. Consequently, by delegating tasks to the technical assistant, the registered nurse can concentrate on providing professional patient care.

The registered nurse is responsible for defining the role, standards, and nursing care activities. By providing direction and supervision, the registered nurse is also accountable for the overall care delivered in the partnership. An official contract is used to confirm the relationship, and both members are paired on the same time schedule.

This system of care delivery is highly sensitive to unit-based human resource distribution requirements, skill mix, competency levels, and patient care needs. Because of the emphasis placed on the delivery of productive and efficient health care services, the partners-in-practice system can yield substantial benefits. These benefits include savings in overall budget and personnel salary expenditures as a result of reduced turnover rates, decreased use of staffing agencies, and improved management of supplemental nursing resources. The system enhances nursing staff retention by offering opportunities for advanced clinical training and education.

Contract and Group Practice Models

Contract and group practice models have been implemented at Johns Hopkins Hospital. They focus on building up the relationship among nursing care providers, the organization, and the environments in which they work. The *contract model* concentrates on promoting job satisfaction and retention

*image
not
available*

*image
not
available*

*image
not
available*

Findings of these studies show that case-managed, in-home support services, such as mental health, respite care, and homemaker or personal care services, have been effective in improving access (evidenced by shorter service waiting lists), assessment, and care-planning needs of elderly clients (Expanded In-home Service for the Elderly Program [EISEP], 1988; Raschko, 1985). Additional studies illustrate the efficacy of case management in coordinating and integrating health and social services for long-term care, assessing quality-of-life outcomes (quality-of-living conditions), and reducing time spent in long-term care facilities (Carcagno & Kemper, 1988; Eggert, Bowlyow, & Nichols, 1980; Sherwood & Morris, 1983).

Because the nursing profession recognizes the need for changes in the system of health care delivery, nurses are increasingly being designated as case managers. This change results from the expertise and knowledge of nurses in managing patient care. Case managers are involved in the assessment, coordination, referral, and individualized planning, monitoring, and follow-up activities associated with case management (Grau, 1984; Johnson & Grant, 1985; Mudinger, 1984).

Primarily used with long-term care populations, case management arrangements have been developed by private insurance carriers as cost-containment strategies and have been integrated into the acute care setting (Henderson & Collard, 1988; McIntosh, 1987). Consequently, different models of case management have evolved. Merrill (1985) identified three categories of case management: social, primary care, and medical-social.

Social Case Management

Social case management models emphasize comprehensive long-term community care services used to delay and/or prevent hospitalization. Both health and social needs are addressed in this setting. Primarily successful with the elderly population, this model focuses on ensuring the independence of the individual through family and community involvement. It is based on a multidisciplinary approach to coordinate the care of the patient.

Various services, from companionship to homemaking, are offered to assist individuals in their daily activities. One example of the social case management approach is the U.S. Department of Housing and Urban Development's Congregate Housing Services Program, in which non-health services are provided to the elderly living in a housing project.

Primary Care Case Management

Primary care case management takes on the role of gatekeeper based on the medical model of care. This approach focuses on the treatment of a particular health problem and tries to prevent institutionalization. In this model the physician functions as the case manager and is responsible for coordinating services and managing the patient (Johnson & Grant, 1985).

Primary care case management emphasizes the need to regulate resource use to ensure cost-effectiveness. Examples mentioned include health management organizations (HMOs), which originally served Medicaid beneficiaries and have become increasingly popular among insurance companies as a means of controlling the disproportionate use of medical care.

Because the patient population accommodated by primary care case management is defined by health status, the type of case management services required varies according to the health needs of the patient. The financial imperatives to curtail high-cost medical technology are strong under the primary care case management system. However, a major liability of this approach is the exclusion of necessary medical services and hospitalization. Johnson and Grant (1985) recommend that quality assurance standards be incorporated into this mode of health care delivery.

*image
not
available*

*image
not
available*

*image
not
available*

Linking Clients to Needed Services

Case managers act as brokers to expedite and follow through with the coordination and planning needs of the client. Both community and agency resources may be used. In some systems, this responsibility involves actually transporting the client to a recommended service.

Service Implementation and Coordination

The case manager ensures that the identified needs are satisfied and follows the formal agreements made with the networking agencies. This is done by extensive documentation and record keeping of the efficiency, effectiveness, and quality of case management care services. A participative relationship of client and case manager and autonomous decision-making on the part of the case manager are crucial to both groups' engagement in the system.

Monitoring Service Delivery

The case manager is responsible for directing and overseeing the distribution of services to the client. A multidisciplinary and multiservice relationship is promoted to ensure appropriate and effective delivery of case-managed services.

Advocacy

Case managers act on behalf of the client in ensuring that needed interventions are obtained and that the client is making progress in the program. As explained by Weil, the advocacy strategy is used not only for the individual client but also for the benefit of all individuals in common predicaments.

Evaluation

The case manager is responsible and accountable for appraising the specific as well as the overall usefulness and effectiveness of case managed services. The evaluation process involves continuous monitoring and analysis of the needs of the individuals and services provided to the clients. Early identification of changes or problems with the client or the provider of services is made, ensuring timely intervention and replanning by the case manager.

References

- Carcagno, G.J., & Kemper, P. (1988). The evolution of the National Long Term Care Demonstration: An overview of the Channeling Demonstration and its evaluation. *Health Services Research, 23*, 1-22.
- Cesta, T.G., & Tahan, H.A. (2003). *The case manager's survival guide: Winning strategies for clinical practice*. 2nd Edition. St. Louis: Mosby, Inc.
- Eggert, G.M., Bowlyow, J.E., & Nichols, C.W. (1980). Gaining control of the long term care system: First returns from Access Experiment. *The Gerontologist, 20*, 356-363.
- Expanded In-home Service for the Elderly Program (1988, November 30). *An evaluation of New York City's home care services supported under the Expanded In-home Service for the Elderly Program*. New York: Health Research, New York University. Funded by New York City's Department for the Aging (contract #11000100).
- Grau, L. (1984). Case management and the nurse. *Geriatric Nurse, 5*, 372-375.
- Henderson, M.G., & Collard, A. (1988). Measuring quality in medical case management programs. *Quality Review Bulletin, 14*(2), 33-39.
- Johnson, C., & Grant, L. (1985). *The nursing home in American society*. Baltimore: Johns Hopkins University Press, pp. 140-200.

*image
not
available*

*image
not
available*

*image
not
available*

Case management is effective because it targets the coordination, integration, and outcome evaluation processes of care. The inherent strengths in case management systems have led to a renewed interest in the utility and effectiveness of such systems.

TREND-SETTING IN NURSING CASE MANAGEMENT

Managed care is a system that provides the generalized structure and focus for managing the use, cost, quality, and effectiveness of health care services. Managed care then becomes an umbrella for several cost-containment initiatives that may involve case management. On the other hand, nursing case management can be conceptualized as a process model, the underpinnings of which are essential in attending to the many components and services used in the delivery aspects of patient care.

With case management, the accountability and responsibility for the delivery of care are based on an entire occurrence of hospitalization for a targeted diagnosis-related group (DRG) of patients and is not geographically confined to that patient's unit (Etheredge, 1989; Zander, 1990). This widens the circumscribed area of patient services to include patient care planning and coordination across health care settings. Case management, then, implies consistency of provider: even though different, formal, informal, and even very esoteric resources are used, the coordinator or provider (usually an individual) remains the same (Zander, 1991).

Collaborative practice arrangements in the form of group practice are supported, and interdisciplinary decision-making is facilitated to ensure appropriate use of patient resources and achievement of expected clinical outcomes. Collaboration usually includes members of the health care team and the patient or family to help accomplish anticipated care outcomes. Participants of the health care team use critical paths, clinical pathways, and case management plans. Variance analysis and evaluation of patient care are expanded beyond the confines of the patient unit and encompass all patients in the specific caseload (Etheredge, 1989; Zander, 1990).

An example of a case management model—the Beth Israel Multidisciplinary Patient Care Model (Cesta, 1991)—was developed for use within an acute care setting. Using the practice concepts of both primary and team nursing, this model supported the coordination and management of patient care from admission to discharge. The objectives of the model were as follows:

- Improve quality of care
- Control resource utilization
- Decrease length of stay
- Increase patient satisfaction
- Increase staff satisfaction

This case management model, which was implemented through a reorganization of the nursing department structure, provided the opportunity for advancement of selected registered nurses working at the bedside. When a case management career ladder is used, nurses who have a baccalaureate degree and who have demonstrated advanced clinical and leadership skills can remain in the direct patient care environment and expand their professional careers by working as case managers.

The case manager was removed from direct care delivery to coordinate overall patient services. This individual is also part of a multidisciplinary team that continually assesses, evaluates, and plans patient care. The assessment is based on expectations regarding outcomes of care of the physician, nurse, and all other individuals involved in the patient's care.

Case managers assumed responsibility for a caseload of patients who met high-risk criteria developed for each clinical area. Patients were referred to utilization management or social work as needed.

*image
not
available*

*image
not
available*

*image
not
available*

attention on longitudinal outcomes. In the future, visual trajectories from these outcomes may be consumer-friendly tools to help client-provider partnerships to understand and manage self-care and health maintenance (Jensen & Koerner, 1999).

References

- Ake, J.M., Bower-Ferris, S., Cesta, T., Gould, D., Greenfield, J., Hayes, P., Maislin, G., & Mezey, M. (1991). The nursing initiatives program: Practice based models for care in hospitals. In *Differentiating nursing practice: Into the twenty-first century*. Kansas City, Mo.: American Academy of Nursing.
- Brett, J.L., Bueno, M., Royal, N., & Sengin, K. (1997). PRO-ACT II™, integrating utilization management, discharge planning, and nursing case management into the outcomes manager role. *JONA* 27(2), 37-45, 1997.
- Cesta, T. (1991, Nov.). *Managed care*, personal correspondence and paper presented at the Annual Symposium on Health Services Research, New York.
- Etheredge, M.L. (1989). *Collaborative care nursing case management*. Chicago: American Hospital Publishing, Inc. (American Hospital Association).
- Jensen, G.C., & Koerner, J. (1999). Longitudinal profiling: A differential community nursing model. In E. Cohen & V. De Back (Eds.), *The outcomes mandate: Case management in health care today* (pp. 153-155). St. Louis, Mosby Inc.
- Koerner, J.G., & Karpiuk, K.L. (1994). *Implementing differentiated nursing practice: Transformation by design*. Gaithersburg, Md.: Aspen Publishers, Inc.
- Koerner, J.E., Bunkers, L., Nelson, B., & Santenna, K. (1989). Implementing differentiated practice: The Sioux Valley Hospital experience. *Journal of Nursing Administration*, 19(2), 13-20.
- Luckenbill, J., & Tonges, M. (1990). Restructured patient care delivery: Evaluation of the ProACT™ model. *Nursing Economics*, 8(1), 36-44.
- Tonges, M. (1989a). Redesigning hospital nursing practice: The professionally advanced care team (ProACT™) model, part I. *Journal of Nursing Administration*, 19(7), 31-38.
- Tonges, M. (1989b). Redesigning hospital nursing practice: The professionally advanced care team (ProACT™) model, part II. *Journal of Nursing Administration*, 19(9), 19-22.
- Zander, K. (1990). Managed care and nursing case management. In G.G. Mayer, M.J. Madden, & E. Lawrenz (Eds.), *Patient care delivery models* (pp. 37-61). Rockville, Md.: Aspen Publishers.
- Zander, K. (1991, April). Presentation at *Nursing care management: Transcending walls opening gates*. Wichita, Kan.: Saint Joseph Medical Center.

*image
not
available*

*image
not
available*

*image
not
available*

this occurs when the physician is doing other things, like seeing patients in the office or making rounds in the hospital. Delays can only increase the likelihood that hospitalization will be extended—an unwelcome disruption of life for most patients and a cost to the health system.

Clinical connections comprise programs and services across the continuum of care and the disciplines that provide care. Streamlined, these connections represent a stage of integration where we have the disciplinary interdependence to provide accessible, quality, and cost-effective care across the continuum and across time.

Interdependence is the key to building a system of clinical connections, or a system of care. We can start shifting to interdependence by inviting all the appropriate clinicians to knit together their collective efforts to assist a group of patients, or a clinical population, presenting a challenge to the health system. This interdependence is similar to a community approach that is inclusive, not exclusive. We look to who will be the right provider to do what for whom, when, where, and why. The interdisciplinary community then becomes a vehicle for mutual exchange, dialogue, and active listening. The clinicians can then organize their efforts across the continuum of care and across time, honing in on the best approach for patients given the resources of the health system.

PRINCIPLE 2: GROUPING PATIENTS

One of the first tasks in care management is to identify groups of people in like situations who feel vulnerable and present a clinical and financial challenge to the health system. These clinically relevant groups or populations are then risk stratified into high-, moderate-, and low-risk situations. Individuals in the high-risk (unique) group may require case management interventions. The interdisciplinary team can then decide which discipline is best suited to become the case manager and develop a system of consultation with the other disciplines to support the designated primary case manager in their care responsibilities. The key in this situation is not to duplicate effort, because it can be confusing to the patient and expensive to the system, not just in dollars but also in needless resource use. The interdisciplinary team can also develop care management approaches for improving the health and well-being of moderate- and low-risk groups of patients within that population.

PRINCIPLE 3: HONORING THE THERAPEUTIC RELATIONSHIP

A key to care management is building a system of care that supports the therapeutic relationship. Care management is not intended to provide a recipe or protocol for treating everyone the same. Rather, the intent is to build a system of care that streamlines the mechanics of health services so providers have more therapeutic time to spend with their patients.

In a letter to the editor, published in the *Arizona Daily Star* (1998), Isla Jacobs, a southern Arizona resident, writes about the importance of relationship: “I lament the direction the medical profession has taken. It’s a big business now and seems to be preoccupied with cold efficiency. Listening to a patient’s problems, whether real or imagined, has gone by the wayside. Two of the most important areas of medicine are trust and patience. In days past the doctor was truly a member of the family.” Although her remarks are addressed to physicians, her words have meaning for every health care provider. Essential to a therapeutic relationship is the capacity to be heard by and be known to the professionals to whom you entrust your health. With meaningful relationships between patients and providers, successful outcomes can be maximized for patients, providers, and the entire health care system.

*image
not
available*

*image
not
available*

*image
not
available*

health care environment. Purchasers and developers of disease management programs are becoming more sophisticated in understanding how programs affect their health care costs, participant quality of life or functional status, consumer satisfaction, clinical outcomes, and, for businesses, productivity of their employees. Statements about “return on investment” must be substantiated with actual health care costs and accurate calculations of cost avoidance. Estimates and approximations are increasingly being replaced with calculations based on actual health care expenditures. Innovative programs will continue to develop and flourish if these programs use data to demonstrate actual health care savings, increased worker productivity, and improved quality of life.

Determining the “teachable moment” for patients or providers, or the point in a treatment algorithm when the greatest health impact can be achieved, continues to provide opportunities for research; a “teachable moment” is that point when the patient is ready and able to change behavior to achieve a healthier state. For providers of health care, it means recognizing where the patient is along the change continuum and providing information and support in concert with the patient’s current status. The *transtheoretical model of change* (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997) is a model of intentional behavior change that describes how people modify a problem behavior or acquire a positive behavior. The model focuses on the decision-making of the individual and his or her readiness to change at each stage. Used in smoking cessation and other addictions, in weight loss, and with people who have chronic conditions, the model is useful in determining when a patient is ready to make a life change and is helpful in determining an approach that yields positive results.

Using a quality improvement framework, determining what interventions have the most impact, is necessary to continuously advance patient care. The timing and type of intervention and how it is delivered via clinician, media, or technology continue to change as new health and patient education innovations enter the market. Research as to the most appropriate and cost-effective type of intervention refines approaches to patient care as well as contain costs. The optimal timing and method of reinforcement of education to sustain a behavior change are critical to learning more about patient education and motivation. All of these areas continue to be fruitful opportunities for research and program evaluation studies.

Disease management continues to change as new and different partnerships emerge. Partnerships among managed care organizations, employers, and disease management programs continue to develop. Employers are using data such as the Health Plan Employer Data Information Set (HEDIS) or the National Committee for Quality Assurance (NCQA) Quality Compass to identify health plans that improve the health and satisfaction of the work force. Contractual relationships between employers and disease management companies have emerged as employers search for ways to have healthy employees who are productively at work (Lumsdon, 1995). Employers may evaluate each health plan’s preventive and disease management interventions to select the insurer who offers well-developed programs with proved and sustained outcomes to help employees maintain and improve their health and ultimately their work productivity.

Accreditation bodies, including the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance, and the American Accreditation Healthcare Commission (URAC), have implemented certification processes for disease management programs. Through accreditation, aggregate outcome analysis may form a standard set of performance measures and ensure program consistency with evidence-based guidelines (Edlin, 2003).

Consumers are being charged by their employers, as well as their care providers, with taking responsibility for their own health status. Lifestyle concerns such as obesity, nutrition, and substance use contribute to overall health state. Although a health care provider can counsel and educate patients about these issues, the ultimate change rests with each patient. Employers in turn are shifting health care costs to their employees

*image
not
available*

*image
not
available*

*image
not
available*

and to provide information on diabetic education. Individualized case management would occur with newly diagnosed members, those recently prescribed insulin pumps, or those recently hospitalized for complications related to their diabetes. Individual case management reinforces the continuing relationship between the patient and the primary care provider, through the use of an individual plan of care.

Understanding who bears the financial risk for health care costs is also an important part of the planning process. Providers may share financial risk with managed care organizations. As the managed care organization communicates data related to quality improvement activities, the practitioner may be rewarded or penalized for compliance with these initiatives. Examples of data sharing would include profiles of patients with diabetes in need of retinal eye examination or lists of patients with congestive heart failure without evidence of prescribed angiotensin-converting enzyme inhibitor medications. Monetary rewards or penalties may be tied to the level of patient compliance and/or physician education about preventive care and chronic conditions.

Todd and Nash (1997) predict that the next generations of disease management will include “truly integrated care” leading to “health management.” They define *integrated care* as a program that aligns care and reimbursement, and they include risk stratification for patients with interventions that are matched to patient risk. Health management encompasses prevention as well as disease management through the “collection of health status, health risk and severity data, and the linkage of this information to clinical and economic outcomes data for the purpose of determining the predictors of health, disability, illness, disease, complications and probability of eventual outcome” (Peterson & Kane, 1997, p. 307).

PLANNING THE INTERVENTION

Planning the intervention includes researching the literature and interviewing colleagues who have implemented similar programs. Published research may contain the outcomes, instruments, and tools suggested to achieve goals. Actual implementation strategies may not be included. Unpublished program information may be presented at professional seminars that assists with other avenues for planning interventions. Direct contact with authors may yield helpful information.

Understanding available human, information, communication, educational, and financial resources is essential. Determining who are the organizational champions, to assist in gaining more of these resources, is also paramount to program success. A clinical team approach to disease management would involve primary care and specialist practitioners, including physicians, nurses, and social workers, as well as pharmacists. Additional assistance from data and financial analysts, quality improvement specialists, and outcome measurement experts would augment the team process and product. Integration of these champions into the planning process assists greatly in achieving program goals.

The proliferation of pharmaceutical companies within this aspect of health care is unprecedented. Often in partnership with data management companies or universities, pharmaceutical companies are attempting to strengthen their programs with the data to support their interventions and costs. The organization must decide if the disease management program will be purchased from a vendor or developed within the company or clinical practice. Each approach has its benefits and drawbacks. A careful analysis of resources also assists the planner and the decision-makers in selecting the “buy or build” route.

Development of a business plan to determine whether to partner with a vendor or develop one’s own program is required. A careful analysis of the partner’s history, scope of services, implementation work plan, measurable outcome results, program costs, and data integrity is conducted. A review of the company’s business alliances may also prove enlightening. If the vendor is linked to a pharmaceutical company, one might explore expectations about drug promotion or formulary placement. Review of sample

*image
not
available*

*image
not
available*

*image
not
available*

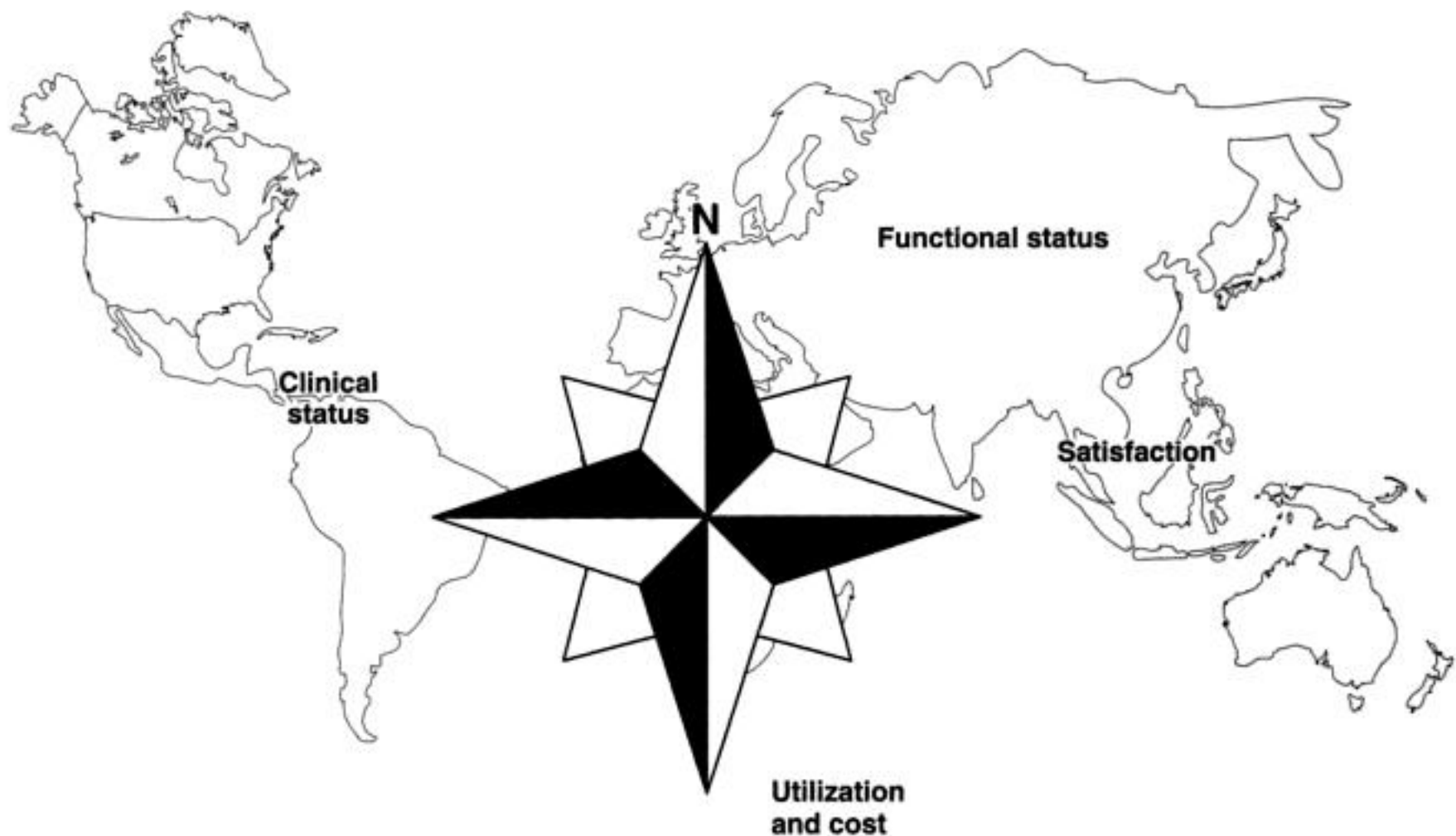


FIGURE 6-2 Clinical Value Compass.

The applicability of the compass directions to measure program outcomes can be used within managed care plans, physician offices, integrated delivery systems, or employer-developed disease management programs. The Clinical Value Compass approach has four cardinal points: functional status, costs, satisfaction with care, and clinical outcomes. Based on outcomes management, this framework allows determination of specific results in each quadrant. These quadrants are representative of not only outcomes management but also the focus of health maintenance organizations, disease, or case management systems.

The directional points of the compass were developed through various research studies (Batalden & Stoltz, 1993; Batalden, Nelson, & Roberts, 1994; Nelson & Batalden, 1993; Nelson & Wasson, 1994). Functional status measures may include standardized instruments such as the Medical Outcomes Study Short-Form 12 or 36 (Ware, Snow, Kosinski, & Gandek, 1993) or a quality-of-life measure specific to the program condition or disease process such as arthritis. Use of these types of tools allows comparison with other populations or published research. Instruments should be valid and reliable rather than "homegrown" to ensure accurate measurement of the outcome. Permission to use the instrument must be obtained before use, to comply with copyright regulations.

Patient satisfaction with the intervention is another measure that is part of the compass framework. Satisfaction surveys may measure participant satisfaction with the type of intervention they perceived they received, the amount of assistance offered by the intervention, and their satisfaction with their personal health outcome following the disease management intervention. Again, a standardized satisfaction survey that is found to be valid and reliable serves as a measure of participant satisfaction.

Health care utilization can be measured through pretest and posttest measures of service delivery. The number and cost of emergency department visits for a defined population of patients with asthma would constitute a utilization measure. Because of the seasonal or episodic variation of this illness as well as enrollment patterns within a managed care plan, continuous enrollment logic may be applied. To ensure accuracy and program evaluation over time, the selection of patients who have been

*image
not
available*

*image
not
available*

*image
not
available*

*image
not
available*

*image
not
available*

*image
not
available*

quality and as a patient care resource for nursing and hospital-wide support services such as laboratory, pharmacy, and respiratory therapy. Quality improvement was also monitored through unit-based quality assurance programs.

Cost-effectiveness, quality of care, and nurses' job satisfaction were also evaluated through retrospective variance analysis of patient charges and length of hospital stay, quality-assurance monitoring, and nurse satisfaction surveys. To date, no data have been published.

SAINT VINCENT'S CATHOLIC MEDICAL CENTERS INTEGRATED CASE MANAGEMENT MODEL

Case management models in the late 1990s were beginning to reflect the need to integrate previously disconnected services. Saint Vincent's Catholic Medical Centers in New York City designed and implemented an integrated design model in 1997. The model integrates three functions of the case manager under one umbrella; these include the clinical coordination/facilitation role of the case manager, utilization management (UM), and discharge planning. Each acute care case manager is unit based and performs these interrelated functions for all patients on the unit to which they are assigned. In the past, each of these functions was performed by a separate care provider. This fragmentation resulted in higher cost, longer length of stay, and an inefficient system.

To make the system more efficient and more responsive to a managed care environment, a number of structural changes were made. These included a redefinition of the functions listed earlier with a realignment of the functions under the role of the case manager. This more streamlined approach to care delivery resulted in a more efficient, integrated care delivery process and reduced the need to "pass the baton" from one team member to the next.

Case managers use guidelines and multidisciplinary action plans as tools in the clinical coordination/facilitation aspect of their role (Appendix 7-1). The guidelines delineate the appropriate resources and length of stay for various case types. The case managers are responsible for collecting variations from the guidelines as part of their daily variance collection process. Other variances collected identify system delays and clinical issues, quality issues, and unmet clinical outcomes.

The data are reviewed daily and individual issues are addressed. The data are also aggregated and reviewed for potential quality improvement efforts. For example, magnetic resonance imaging (MRI) delays are collected in the following four categories that identify the cause of the delay:

- Delays related to scheduling
- Delays related to lack of weekend availability
- Delays related to unavailable reports
- Delays related to equipment failure

Repetitive, substantive delays are addressed in terms of the cause of the problem and potential solutions. An interdisciplinary team is often assembled to address the problem and develop an action plan for correcting the problem.

In the role of clinical coordinator and facilitator, a number of functions may be performed; among these are development of the interdisciplinary plan of care and expediting diagnostic testing and treatments as identified by the plan of care. This clinical focus fosters a partnership with the physicians and other members of the health care team. It allows the case manager to identify and suggest opportunities to deliver care more efficiently and/or at lower cost.

The case managers are also responsible for performing UM functions. This includes using established review criteria such as the Milliman and Robertson Guidelines (Doyle & Schibanoff, 1997) to perform insurance reviews. They are in daily communication with the third-party payer and work to ensure that the hospital is reimbursed for every day that the patient is in the acute care setting. Services are reviewed

*image
not
available*

*image
not
available*

*image
not
available*

transferred electronically to the unit-based case manager. The collaborative effort performed by the admitting and emergency department case managers helps prevent inappropriate or unnecessary admissions and ensures that the patient is receiving the care needed in the most appropriate setting.

The design of the case management model at Saint Vincent's connects three role functions that had been disconnected in the previous care delivery system. This integrated approach reduces redundancy, duplication, and delays. Within the first year of implementation, the hospital achieved its target goal length of stay reduction of 1.1 days. Insurance denials were reduced by 30% in medical/surgical and by 80% in psychiatry. Patient complaints regarding discharge planning and communication of the plan of care were reduced by 20%.

TUCSON MEDICAL CENTER CASE MANAGEMENT MODEL

JoAnne Woodall

Past

A case management model developed at Tucson Medical Center (TMC) in the late 1980s addressed the cost and quality aspects of patient care delivery (Del Togno-Armanasco, Olivas, & Harter, 1989). This approach incorporated elements of the New England Medical Center's case management model and differentiated practice models in addition to basic philosophic practice components of primary nursing and shared governance.

Called *collaborative nursing case management*, this model primarily focused on standardizing the use of patient care resources and the delivery of services during the patient's hospitalization for selected DRG case types. Both patient mix and service volume management strategies were used to attain cost-effective, quality patient care (Olivas et al., 1989a).

A collaborative case management plan (CCMP) and a care plan MAP were used to identify the contributions of all health care providers and to support a unit-specific standard of patient care. Variations from practice standards were also monitored and evaluated. The care plan MAP was revised in 1991 to meet requirements of the Joint Commission on Accreditation of Healthcare Organizations (Gwozdz & Del Togno-Armanasco, 1992). It was also used as a basic documentation form.

Hospitalwide and unit-specific multidisciplinary practice committees were established to assist in clinical decision-making and overall evaluation processes of the patient care model. These groups consisted of physical therapists, dietitians, social workers, physicians, and home care professionals (Olivas et al., 1989b). Patients were encouraged to participate and were included in the planning of their care regimens, which are carried out on a continuous basis from the time of admission to after discharge.

Various evaluation mechanisms were developed to measure the potential impact of this case management model on outcomes of care. A patient satisfaction questionnaire and a retrospective chart review were implemented along with a physician-satisfaction-with-care questionnaire to ascertain variables related to patient care and job satisfaction. Information on cost of care, rate of absenteeism, and staff turnover also were collected. Findings showed increased satisfaction with both nursing and medical care (at the .05 alpha level) for case-managed, total hip replacement, coronary bypass, and valvular surgery patients. There was no turnover of nurse case managers, and a marked decrease in turnover rates was demonstrated for nursing staff on the oncology and orthopedic units.

Outcome data also showed a decreased length of stay among patients who underwent total hip and knee replacements. The decrease was 3.48 and 2.82 days, respectively, over a 3.5-year period. Length of stay for valvular replacement and coronary bypass patients also decreased. In addition, a positive cost

*image
not
available*

*image
not
available*

*image
not
available*

the organization. The most notable outcome of this era of reorganization of case management was the emergence of a nursing and social work case management staff that has become highly cross-trained. With reduced numbers, the nurses and social workers no longer had the luxury of sharing cases, but they increasingly trained each other to handle issues and situations traditionally seen as “strictly social work” or as “strictly nursing.” Although these specialties within the case management team still consult freely and frequently with each other, there is a much greater sense of “cross-competence” between the disciplines. The TMC model still recognizes the unique functions of each of its specialties (see Appendix 7-4), but the lines between the sets of specific specialty functions have blurred.

Case managers are also much more comfortable moving between clinical service lines in the hospital. With a strong case management identity, staff members see themselves less as “cardiac” or “neuro” case managers and more as case management specialists who have a body of skills and knowledge that can be generalized to many different environments. There also is a per diem staff, made up of nurse and social work case managers who float to provide the ability to staff up or down depending on census or need. These changes have improved the flexibility and efficiency of the department. With this flexibility, we have been able to provide weekend coverage for the hospital as well as on-call coverage for evening hours, with no increase in FTEs.

Our emergency department case management model has undergone major reengineering. During the staff reduction period, the emergency department case management position was eliminated. The original purpose for having a case manager in the emergency department was to have a “gatekeeper” to divert unnecessary admissions during the time when TMC had capitated contracts. With changes in contracting, the capitated risk went away, health plans became the gatekeepers, and the primary purpose for emergency department case management diminished. However, new challenges, as fed by the nursing shortage, reduced numbers of staffed beds, and emergency department bottlenecks, created a mandate to bring back the emergency department case management position. This time, the purpose is to help to decompress the emergency department by facilitating the speedy discharge of patients not requiring hospitalization and to contribute to the timely movement of patients through the system. This change, along with a host of other process changes taking place throughout the system, contributed to the reduction of emergency department divert time from approximately 60% to less than 10%. The emergency department case manager also handles issues that were previously thought to be “social work” issues, greatly reducing the need for social workers to leave their units to respond to needs in the emergency department.

The utilization case managers have also evolved significantly over the past 3 years. The staff has increased from two to four FTEs. It was recognized that even though all case managers have a responsibility for resource and UM, the formal review functions were not being given the attention that they required when placed on the already overfull plate of the case managers. So, with the exception of two highly specialized populations—pediatrics and high-risk antepartum—the reviews are being done by the utilization staff. The UM approach has become more proactive and interactive with the rest of the case management staff as well as the entire health care team in an effort to identify and reduce avoidable days and denials. In addition, the UM staff is actively involved in concurrent DRG assignment and physician education to ensure accurate documentation. This effort has improved coding accuracy, allowed for more accurate reimbursement, and supported a morbidity and mortality profile that more accurately reflects the acuity and complexity of the patients treated at TMC.

Case management at TMC has its roots in the need to become more efficient and cost-effective in providing quality services to patients and families. We are continually finding new and better ways to do this as the health care environment presents us with new challenges. Members of the TMC case management department believe that even though the change process has been painful at times, we have emerged a stronger, more flexible, and more effective team.

*image
not
available*

*image
not
available*

*image
not
available*

ST. VINCENT'S HOSPITAL AND MEDICAL CENTER MULTIDISCIPLINARY ACTION PLAN DAY OF SURGERY

Procedure: Carotid Endarterectomy

MD: _____

RN: _____

Date: _____

Patient Problem and Nursing Interventions	Expected Patient Outcome and/or Discharge Outcome	Assessment/Evaluation		
Alteration in Body Systems	Complications will be Prevented/Minimized			
1. Nursing assessment A. Vital signs & neurovascular check B. A-line C. Assess orientation to person, place & time D. Assess lung sounds & RR E. Assess if neck dressing is intact, and/or for the presence of drainage/bleeding. HOB ↑ 30° F. Palpate abdomen, noting distention or discomfort. Auscultate for bowel sounds. Assess presence or absence of nausea, vomiting and flatus Advance diet G. Assess bladder for distention H. Assess circulation and mobility of extremities I. Assess IV site for redness, edema, & pain. Ascertain IV is patent & infusing	A. VS & neurovascular status WNL B. Hemodynamically stable C. Oriented to person, place, & time D. Respirations unlabored & even; lungs clear. Using incentive spirometer, coughing and deep breathing E. Neck dressing dry and intact F. Abdomen soft, not distended Minimal/no nausea/vomiting Tolerating diet G. No signs/symptom of complications Voiding without difficulty H. No signs/symptoms of complications I. No signs/symptoms of complications IV D/C'd when stable & tolerating fluids	1. A. (Flow sheet) B. (Flow sheet) C. (Flow sheet) D. (Flow sheet) E. (Flow sheet) F. (Flow sheet) G. (Flow sheet) H. (Flow sheet) I. (Flow sheet)	1. A. (Flow sheet) B. (Flow sheet) C. (Flow sheet) D. (Flow sheet) E. (Flow sheet) F. (Flow sheet) G. (Flow sheet) H. (Flow sheet) I. (Flow sheet)	1. A. (Flow sheet) B. (Flow sheet) C. (Flow sheet) D. (Flow sheet) E. (Flow sheet) F. (Flow sheet) G. (Flow sheet) H. (Flow sheet) I. (Flow sheet)
Alteration in Comfort	Pain R/T Postoperative Period will be Prevented/Minimized			
1. Incisional pain: A. Assess level of pain (use 1-10 pain scale) B. Administer pain medications C. Assess effect of pain medication D. Use comfort measures and diversional measures	1. Verbalize minimal discomfort after Intervention implemented 2. Attain identified goal of pain relief	1. (Flow sheet)/(MAR)	1. (Flow sheet)/(MAR)	1. (Flow sheet)/(MAR)
Knowledge Deficit R/T Surgical Procedure and Discharge Planning	Increased Knowledge R/T Postoperative Care & Discharge Planning			
1. Assess knowledge/instruct/evaluate re: ■ Pain relief ■ Preventive postoperative measures.	1. Verbalize understanding &/or Demonstrate: ■ Preventive postoperative measures & pain relief	1.	1.	1.
2. Review plan of care, including possible discharge date and follow-up plan	2. Verbalize understanding of plan of care, discharge date & time, & follow-up plan	2. (Discharge summary)	2. (Discharge summary)	2. (Discharge summary)

MAP009 (10/98)

Copyright © St. Vincent's Hospitals and Medical Center, 1998.

All Rights Reserved.

*image
not
available*

*image
not
available*

*image
not
available*

Core Case Management Functions and Specific Specialty Functions

CORE CASE MANAGEMENT FUNCTIONS

The case manager will act to:

- Identify at-risk populations for high cost, extended lengths of stay, destabilization, and repeat hospitalization
- Coordinate resources to ensure that necessary services are provided at the most appropriate level of care and that there is a smooth progression of the patient throughout the system during hospitalization
- Initiate a discharge planning process, beginning at or before hospital admission, that ensures safe and comprehensive support for continued health care needs
- Anticipate potential delays in the health care process, and act proactively to avoid these delays
- Identify obstacles to efficiency and good outcomes, and intervene to overcome or eliminate these when possible
- Reduce redundancy and fragmentation of care by acting as a communication link between the patient, family, members of the health care team, and payers
- Gather, interpret, and use data to identify problems and trends and to demonstrate outcomes and cost-effectiveness
- Act as advocate for the patient and family
- Educate the patient, family, and interdisciplinary team regarding health care resources
- Share skills and expertise with case management team

SPECIFIC SPECIALTY FUNCTIONS

Utilization Case Manager	Nurse Case Manager	Social Worker Case Manager
1. Perform utilization review for appropriateness of admission, continued stay, and placement	1. Perform case management assessments	1. Perform case management assessments
2. Identify and refer high-risk complex patients for ongoing case management	2. Interact with patients, families, physicians, and other health team members to develop proactive plans for continued care	2. Interact with patients, families, physicians, and other health team members to develop proactive plans for continued care
3. Function as expert resource for rules/regulations regarding utilization management	3. Evaluate and modify plan according to changing patient needs and clinical data; document and communicate plan to all team members	3. Evaluate and modify plan according to changing patient needs; document and communicate plan to all team members

*image
not
available*

*image
not
available*

*image
not
available*

complicated, collaborative models of case management ensure the availability of the competencies, knowledge, and skills necessary to the task at hand. With a clear sense of direction, collaborative case management teams can provide higher-quality solutions than any one individual working alone or in traditional multidisciplinary relationships.

THE EVOLUTION OF A COLLABORATIVE MODEL

In 1994, Tennessee was faced with the rapid conversion to a Medicaid managed care model. Vanderbilt University Medical Center (VUMC) recognized the need for change to ensure a competitive position in the new environment. At the VUMC, costs were significantly higher than those of local competitors and the length of stay was high. The development and initiation of a case management model were seen as important elements in developing a competitive edge and responding to the managed care challenge.

In recognizing the strength brought by a diverse skill mix and the role conflict created by collapsing jobs (Erickson, 1996), case management was seen, from its inception, as the responsibility of a triad of nurse case manager, social worker, and utilization manager (Figure 8-1). *Case management* was defined as

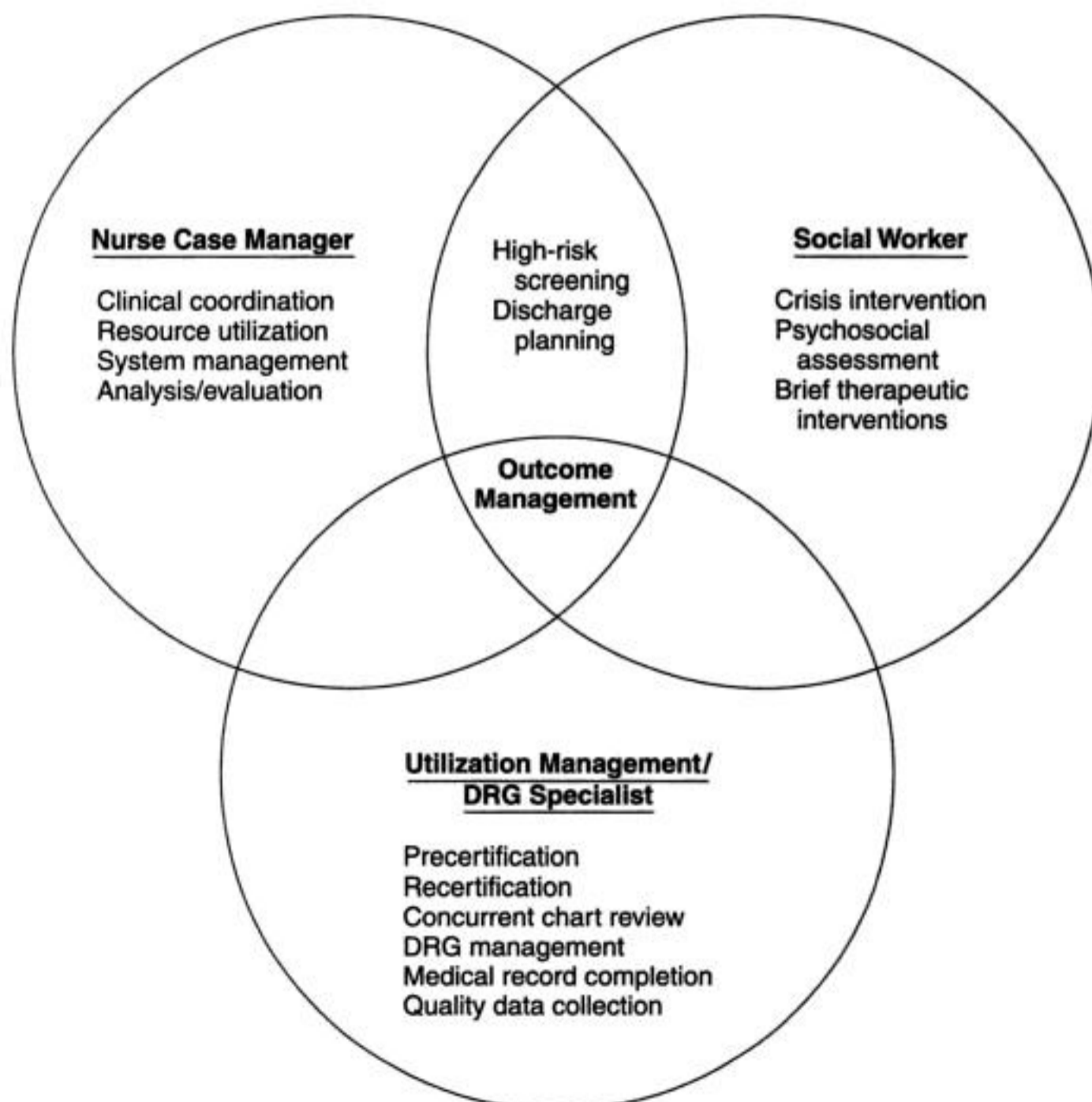


FIGURE 8-1 Case management triad.

*image
not
available*

*image
not
available*

*image
not
available*

Team chartering is an efficient, effective method of helping the team define how they will work together. The charter has several elements:

- The purpose of the team
- The scope of the team's work
- Givens or boundaries (those things that cannot be changed)
- Decision-making process and fallback (how decisions will be made and the fallback if agreement cannot be reached)
- Roles (individual and collective responsibilities of team members, including professional roles and roles within the team, such as leadership)
- Norms and ground rules (how members work together)
- Meetings (times and frequency)
- Supports for the team (the supports necessary to ensure success)

Our experience demonstrates that chartered teams function more effectively, as there is commonality of purpose and a defined structure. If the team has problems in functioning, the charter serves as a reference for corrective action. It is also a critical tool in the orientation of new team members.

Because collaborative practice requires interdependence, it has also been helpful to assist team members in understanding and valuing individual style. A helpful tool is the Myers-Briggs Type Indicator. Team members complete the inventory and receive an individual interpretation of style preferences. In a group session, all team member preferences are shared and the group learns how individual style impacts the team, the potential inherent in style diversity, and methods to use diverse styles in optimizing team function.

Managing conflict is a major challenge to teams. Each team needs help in "acknowledging and using conflict productively versus suppressing and ignoring it" (Liedtka & Whitten, 1997). The Myers-Briggs tool provides a method for understanding team members' reactions and provides direction in helping people adapt (Barger & Kirby, 1995). The concept of *planned renegotiation* is also useful. It is a way to provide controlled change by using "pinches" (indicators of personal discomfort), to anticipate team disruption, and to renegotiate expectations before serious disruption occurs (Sherwood & Glidewell, 1972). The Thomas-Kilmann Conflict Mode Instrument can be useful because it focuses on the individual style used most often in conflictual situations, the adaptiveness of that style, and ways to develop flexibility in matching style to circumstance (Thomas & Kilmann, 1974). Any or all of these tools can be introduced for use by the team.

PREPARING TEAM MEMBERS

Curricula necessary to the preparation of new case management staff have been well documented (Cohen & Cesta, 1997; Satinsky, 1995; Tahan, 1996). Core content includes the history of case management; case management models; health care trends; payer networks and contracts; systems of reimbursement; case management practice (risk screening, assessment, care planning and evaluation, and continuum of care planning); pathway creation; continuous improvement techniques; and outcomes measurement and management. However, a collaborative model requires that content be reframed to emphasize interdependence and joint accountability.

Orientation begins with the vision for case management and its relationship to the institutional mission and goals. The collaborative aspect of the vision, with its functional interdependence and joint accountability, is emphasized. Information on the characteristics of well-functioning teams is provided. Participants are asked to complete an inventory of their assumptions about teams, and those are contrasted to the reality of the collaborative model (Harper, 1992). If individuals are joining a functioning team, they review the team charter to understand its purpose and structure. Because the introduction of a new member changes team dynamics, renegotiation of roles may be necessary. Material on conflict

management is provided to new staff, and they are given the opportunity to practice conflict management techniques. They are also given an understanding of personal style and its impact. Again, if they are joining an established team, they learn how their style complements the team. When core content is presented, it includes reference to the way tasks are carried out in a collaborative model and how joint accountability is measured. Mentors assigned are responsible for assisting in the mastery of case management process and collaborative practice.

EVALUATING THE TEAM

Members of the collaborative teams have both individual and joint accountability. There is individual accountability for the quality of professional practice and for behavior as a team member. There is joint accountability for team functioning and outcomes. Expected outcomes are specific to each team, and a communication loop exists that requires the team to regularly report on its progress and to self-adjust as necessary. Successful individual practice does not result in positive evaluation if the team is failing and this is clearly communicated. Positive evaluation requires individual and team success. This is a unique message to most professionals, necessitating repetition.

SUMMARY

Case management practice continues to evolve. The developing collaborative models provide an alternative to traditional case management models, and outcomes demonstrate the synergy that can develop among members of a well-functioning collaborative team.

References

- Bach, D. et al. (1996). Developing a successful hospital case management system. In D. Flarey & S. Blancett (Eds.), *Handbook of nursing case management*. Gaithersburg, Md.: Aspen.
- Barger, N., & Kirby, L. (1995). *The challenge of change in organizations, helping employees thrive in the new frontier*. Palo Alto: Davies-Black Publishing.
- Blancett, S., & Flarey, D. (1996). Case management: The shape of things to come. In D. Flarey & S. Blancett (Eds.), *Handbook of nursing case management*. Gaithersburg, Md.: Aspen.
- Cesta, T. et al. (1998). *The case manager's survival guide, winning strategies for clinical practice*. St. Louis: Mosby Inc.
- Cohen, E., & Cesta, T. (1997). *Nursing case management, from concept to evaluation*, 2nd Edition. St. Louis: Mosby Inc.
- Erickson, S. (1996, July/Aug.). Case management. *Issues and Outcomes*, 6-8.
- Erickson, S. (1997). Unpublished presentation.
- Erickson, S. (1998). The Vanderbilt model of outcomes management. *Critical Care Nursing Clinics of North America* 10(1), 13-20.
- Harper, A., & Harper, B. (1992). *Skill-building for self-directed team members*. New York: MW Corporation.
- Huszczko, G. (1996). *Tools for team excellence*. Palo Alto: Davis-Black Publishing.
- Kidd, K., & White, S. (1998). Unpublished manuscript.
- Liedtka, J., & Whitten, E. (1997). Building better patient care services: A collaborative approach. *Health Care Management Review* 22(3), 16-24.
- Lyon, J. (1993). Models of nursing care delivery and case management: Clarification of terms. *Nursing Economics* 11(3), 163-169.
- Satinsky, M. (1995). *An executive guide to case management strategies*. Chicago: American Hospital Publishing, Inc.
- Senge, P. (1990). *The fifth discipline*. New York: Doubleday.

- Sherwood, J., & Glidewell, J. (1972). Planned renegotiation: A norm setting OD intervention. In W. Burke, (Ed.), *Contemporary organization development, approaches and interventions*. Washington, D.C.: NTL Learning Resources Corporation.
- Tahan, H. (1996). Training and education needs of case managers. In D. Flarey, & S. Blancett, (Eds.), *Handbook of nursing case management*. Gaithersburg, Md.: Aspen.
- Thomas, K., & Kilmann, R. (1974). *Thomas-Kilmann conflict mode instrument*. Santa Clara, Calif.: Xicom, Inc.
- Vanderbilt University Medical Center, Center for Patient Care Innovation. (1994). Unpublished material.
- Vanderbilt University Medical Center, Office of Case Management. (1998). Unpublished results.
- Whiteside, J. (1993). *The Phoenix agenda*. Essex Junction, Vt.: Oliver Wight Publications, Inc.

Case Management

A Process, Not a Person

*Theresa J. Ortiz
Lynn Riippi*

Gambar dengan hak cipta

THE CASE MANAGEMENT PROGRAM

The case management model chosen by an institution is determined by many factors and does not remain static. The University of Colorado Hospital is a 450-bed tertiary care hospital located in Denver, Colorado. The initial case management program used dyads of social workers and nurse case managers. The program was successful and brought many positive changes to the organization. Program evaluation was an ongoing part of the process, resulting in modifications to meet patient, payer, and organizational needs. Having the case managers function in the dual role of case and utilization manager demonstrated value. The case managers began to understand the payer role in the process and increased their negotiation and brokering skills. However, over time, program evaluation demonstrated that the workload needed to be adjusted. Various models were evaluated, and a site visit was made to Vanderbilt University to observe their triad model (see Chapter 8). This model added a third component to the dyads, the utilization management nurse, creating a triad. The teams started out as hospital unit based and gradually transitioned to population-based teams, many of whom follow their patients across the continuum of care.

The evolution of University of Colorado Hospital's case management program began with the identification of multiple factors, including the hospital's mission and the competitive managed health care market. The hospital's mission includes education, research, and service to the indigent. When designing a case

management model in an academic setting, additional factors may need to be considered, depending on the relationship between medical school, physician group practice, and hospital. Balancing the hospital's mission becomes difficult because the key players are often working toward different objectives. At times their motivating factors may even be in conflict with one another (Table 9-1).

Recognizing that aligning incentives between these three entities was a monumental task, the model was designed to start with what was controllable. Historically, no group other than the utilization review department had been accountable for the utilization of resources and patient length of stay. Staff in general had little understanding of managed care, reimbursement, covered and noncovered benefits, or internal and external resources. In addition, lacking was the concept that case management is a process that includes many disciplines, all of which have a part in coordinating care.

The optimal situation would be to design a model, hire staff with specific expertise, close the health care system for at least 1 week to ensure large blocks of training time, and then, when fully prepared, begin the program. In most institutions, limited budgets, systems constraints, and administrative expectations for quick results do not allow the staff time for adjustment and mastery of new skill sets. The model was piloted in just such an environment. Almost immediately the human barriers to implementation began to surface (Table 9-2).

Database Design

As the demand to demonstrate added value in the patient care process increases, case management programs must develop a mechanism to trend system issues (i.e., variances) that affect patient care, resource utilization, length of stay, etc. Data must be formatted so as to identify areas for performance improvement activities, track triad team-productivity, and serve as a decision-making tool for administration. The case management team database at University of Colorado Hospital, like the program model, has gone through multiple permutations. The original hand-tallied tool was designed to capture variations in patient care that prevented a smooth transition through the hospital stay (e.g., a discharge is postponed because a test could not be performed on a timely basis). The foundation for the database was a data entry sheet completed by the case management teams that identified and assigned

WHAT ARE THE MOTIVATING FACTORS FOR EACH GROUP?

Medical School

How is the hospital reimbursed for the additional costs associated with training?

Students must meet minimal requirements for graduation.

Need to perform required number of procedures, which may not always incorporate utilization management principles

Physician Group

Physicians trying to balance academic medicine, research, clinical responsibilities, and the reality of managed care

Physicians develop their own practice patterns. Residents "adopt" the personality of the attending physician.

University Hospital

Competing in a stage 4 managed care market on costs

Reimbursement declining

Need to contain resource utilization

HUMAN BARRIERS EXPERIENCED IN IMPLEMENTATION OF THE CASE MANAGEMENT MODEL

Fear	Staff Response	Rationale for Fears	Leadership Strategies	Outcomes
Fear of losing my job	"If I do not go along with this model, I will lose my job."	Case management programs nationwide had eliminated or changed roles for social workers and clinical nurse specialists	Use of a consultant with strong managed care background	Consultant provided an objective view for program development and was able to solicit cooperation from multiple departments
Fear of change	"What do I do everyday in this new role?"	New role, new expectations, new job skills, new partner Feeling of being overwhelmed was real for health care professionals who were very skilled and comfortable in their "old" roles	Clear structure and accountabilities provided for framework for daily expectations Job descriptions with performance standards developed	Took approximately 6 to 9 months for teams to demonstrate team behavior
Fear of managed care	"I would have gone to business school if I had wanted to deal with finances. I am trained to care for patients."	Fear of managed care in a stage 4 managed care market is a reality. Hospitals in this market were downsizing, consolidating, and/or closing Lack of understanding about managed care rules and how to incorporate these into a patient treatment plan were new skill sets that needed to be learned.	"Managed Care 101" training Day-long training session for case management teams Training on developing a relationship with a third-party payer	Teams have become less intimidated by third-party payers Teams see that their role as "financial stewards" for the patient is just as important as their clinical care

These human barriers, although less tangible, were as much of a challenge to leadership as selecting the right model for the particular setting, developing the right report formats, or refining the data base.

Continued

HUMAN BARRIERS EXPERIENCED IN IMPLEMENTATION OF THE CASE MANAGEMENT MODEL—CONT'D

Fear	Staff Response	Rationale for Fears	Leadership Strategies	Outcomes
Fear of technology	"Why do we have to keep data? I'm a caregiver. People should know that I do a good job."	<p>"What value do your services add to patient care?"</p> <p>This is a question being asked by health care companies as well as administration. Fear of data and technology may be real to health care professionals who have not been exposed to computers, data collection, or evaluation of care provided</p>	<p>Education stressing "data is your friend"</p> <ul style="list-style-type: none"> ■ Technical computer training ■ Development of tools for data collection ■ Development of a database ■ Development of usable report formats ■ Education on data analysis ■ Leadership training in data presentation ■ Training in the quality improvement process 	Teams began to understand their data, began to present it to various committees (i.e., clinical pathway team), and became involved with strategies for improvement

variance days to the responsible party. The responsible party may have been a hospital department (e.g., no available operating rooms), a nursing unit (e.g., delay in getting a medication started), a physician (e.g., delay in moving a patient to a lower level of care), or discharge planning (e.g., patient refuses to leave the hospital once he or she is determined to be medically stable). Completing the data entry sheet was an educational experience for most of the case management team members, who were not used to tracking outcomes this way. Identifying and assigning variances forced the case management teams to become more proactive in searching for creative funding and placement options.

The case management database (on Microsoft Access) was designed with a software expert from the financial department and consisted of all University of Colorado Hospital inpatients after diagnosis-related

HUMAN BARRIERS EXPERIENCED IN IMPLEMENTATION OF THE CASE MANAGEMENT MODEL—CONT'D

Fear	Staff Response	Rationale for Fears	Leadership Strategies	Outcomes
Fear of being the "bad guy"	"I do not want to be seen as the utilization management police." or "It's not my place to question the physician."	Staff was used to functioning in a clinical role but not in a total patient care coordination role that included attention to financial issues. Understanding that there are limits in providing care and that patients do have responsibilities in their care were new skill sets to be learned	<p>One-on-one supervision and case review with managers</p> <p>Relationship building with all health care team members. Focus on the fact that patients are the center of what we do.</p> <p>Education about the "big system" perspective</p> <ul style="list-style-type: none"> ■ Guest lecture from finance discussed how health care dollars are spent in our institution. 	<p>Teams developed relationship with business contracting department</p> <p>Staff became more sophisticated in negotiating for benefit exceptions based on cost analysis.</p>

group (DRG) assignments had been made. Once the medical records were coded, they were downloaded into the database. Along with the DRG assignment, demographic data, length of stay, and hospital charges were also included. The program calculated the cost of a variance by multiplying the average variable direct cost per day of the assigned DRG by the number of days assigned. For example, if the patient's length of stay was decreased by 5 days and the variable cost of the DRG was \$500 per day, the facility would potentially save \$2500. This formula may not work for all institutions but was a way to begin showing how variances affect the financial part of providing care for patients. Not all variances were negative; if the case management team intervened (facilitated a test being done earlier or negotiated for benefits with a third-party payer) and it resulted in a decreased length of stay, the team received credit for the intervention.

Specialized reports were taken to medical quality improvement committees to analyze trends. General monthly summaries were reported to the triad teams, administration, physician, and nursing unit manager. The summaries helped each group develop interventions for system areas that needed improvement.

Eventually, the triads determined the data tool should be simplified. Because baseline data were established, it was no longer necessary to track all cases. The interdisciplinary Case Management Department partnered with the Quality and Outcomes Department to automate the tool by making it able to be scanned. Organizational strategic goals were used to determine which streamlined data should now be collected. For example, the hospital is currently focusing on improved quality and utilization management for Medicare patients. The organization wants to provide the best quality care at the lowest cost. Thus, the triad teams currently collect data on the Case Management Department outcomes and interventions related to the Medicare population. An example of data collected includes patients readmitted for the same diagnosis within 30 days. This allows the teams to examine whether the readmission could have been prevented by an alternative discharge planning intervention after the first admission. As organizational goals modify over time, it is likely the data collected and outcomes will again change. The process must remain fluid to continue to render the data useful and meaningful.

Outcomes

A newly formed case management department early in its organizational process might set goals different from those of a more mature program. The early dyad case management program resulted in a number of positive outcomes (Riippi & Jackson, 1997). To date, these outcomes have been maintained, including the following:

1. A decrease in the number of patients on the "\$100,000" report. (This report lists patients whose hospital charges have reached a threshold.) This means there are significantly fewer dollars outstanding in accounts receivable. This outcome really got the attention of the hospital chief financial officer, who reviewed these reports weekly. When possible, case managers and social workers are placing these patients in more appropriate settings sooner and/or obtaining funding to help these patients access resources. Discharges directly from the intensive care unit increased instead of requiring the patient to stay another day in a less acute bed for the purpose of discharge planning.
2. The overall readmission rate has decreased. Teams are coordinating follow-up care and return appointments with primary care physicians, clinics, and home care.
3. Emergency department referrals to social workers and case managers have increased, allowing staff to intervene initially and look for appropriate solutions to patients' situations. They now often divert inappropriate admissions. Teams also identified patients who visited the emergency department frequently and developed alternative follow-up plans, thus reducing the frequency of return visits.
4. Improved customer satisfaction is reflected in telephone calls and letters, as well as satisfaction surveys. These customers include not only patients but also internal customers in other departments and external third-party payer case managers.
5. A significant decrease occurred in the monies spent on home care for the indigent. Case management teams were able to work out more cost-effective alternatives for these patients that did not compromise care.
6. Dollars paid to an outside vendor for home infusion services to the indigent decreased from \$500,000 to \$70,000 the first year the program was piloted. By the third year the spending had decreased to under \$30,000. Currently the spending is under \$10,000 per year. Teams were taught to use an algorithm for possible alternatives to home infusion services. Patients received the same level of service but at times in an alternative setting.

An unexpected bonus to the initial implementation of the case management program was the networking that developed. Collaboration has increased and patients are moving more smoothly between units and services.

With the transition to the triad model and the addition of the utilization management nurses, additional outcomes have been achieved:

1. To date, approximately \$5 million in overturned denials has been recouped as revenue for the organization. (This dollar amount reflects organizational cost.) In addition, follow-up for appeal of denials has been reorganized and centralized. Previously, denials went to various parts of the organization, making it difficult to tabulate a denial rate. A denial log has been placed on a shared computer drive so that the Strategic Development and Business Offices have access to this information.
2. Organized physician education was implemented to improve documentation related to the type of patient admission (i.e., acute admission status versus observation status) that affects reimbursement.

STAGES OF PROGRAM DEVELOPMENT FROM THE HUMAN PERSPECTIVE

Stage 1

As the program was implemented, weekly interdisciplinary meetings were held, consisting of nurse case managers, social workers, home care coordinators, and at times third-party payer case managers. At this point staff was working in dyads as teams, but true team behavior had not yet developed. Nurse case managers and social workers sat on opposite sides of the room, receiving information on the technical aspects and expectations of the new program. In-service training was provided on topics such as medical necessity and level of care criteria, high-risk screening, and Medicare and Medicaid regulations. Staff was learning their accountabilities, competency expectations, and the like. They listened but clearly had not yet internalized the process. Questions were basic and technical in nature and displayed a high level of anxiety. Questions about third-party payers were phrased to indicate staff viewed the third-party payer as the “bad guy.” Staff did not yet display creativity in options for patients. Often they would advocate for whatever the physician had requested, not yet evaluating whether the request was appropriate or whether there were quality cost-effective alternatives. At the end of meetings, people left immediately without much interaction.

Stage 2

Staff began to implement the model and started to accept that they will have a partner. Beginning compliance with requirements appeared, but teams still required extensive one-on-one supervision. Next appeared the predictable power struggles over role definition. Although job descriptions delineated separate duties, there were some gray areas of responsibility, forcing each dyad to negotiate a working relationship. Most teams worked out acceptable arrangements without intervention; one or two required mediation. The individual personalities of team members caused each dyad to have a unique team personality. Most teams blended well and were able to demonstrate flexibility in working out role assignments.

Stage 3

Teams began to develop a consistent daily routine. The need for supervision on cases decreased to occasional supervision on complex cases. Teams began to consult with internal institutional resources, for example, consulting with the wound care nurse to help a patient improve faster or consulting with the pharmacy to enable a patient to obtain a drug on the correct insurance formulary. Less input from

leadership was necessary. More creative planning for cases, incorporating benefit management, financial concerns, patient clinical needs, and psychosocial needs, began to appear. Teams now began to solicit input from all disciplines, such as physical or occupational therapy, speech, and respiratory therapy as well as the physician, and incorporate their input into the plan. However, at this stage, when they were presented with data about their team/unit, they were unclear as to how to utilize and analyze. "This is a nice report. Now what am I supposed to do with it?" was often the response.

Stage 4

Cooperation emerged within teams, and they began to function as true working partners, even completing some cross-training with each other. This was in sharp contrast to the initial stages, when staff members were territorial about their job duties. Teams now tolerated more shades of gray in role definition, allowing for greater cooperation. Most teams adapted to using the strengths of each partner. The comfort level of approaching physicians proactively for discharge plans versus waiting for a physician recommendation increased tremendously. Questions in meetings became more sophisticated, indicating a new level of knowledge and skill sets and demonstrating a broader system perspective.

Participants began to analyze their data for the purposes of improvements in contrast to the attitude, "I don't want this data to make me look bad." Data were presented to groups outside the team, for example, at a clinical pathway or medical staff quality meeting.

Stage 5 (Current)

As the insurance industry demands evolved, the need for a gradual metamorphosis of the model emerged. Continued evaluation of institutional and patient needs had become crucial. As the program evolved from the dyad to the triad model, the teams went back through the cycle of adjustment to change but at a higher level of expertise. Teams became healthier and stronger, and a staff-based self-governance committee was formed. The committee has been delegated responsibility for development of protocols for issues such as vacation leave coverage and case management documentation standards. Clearly, the model is beginning to expand from a program to a systemwide way of thinking, incorporating other key players in decision-making and development. Case management truly becomes not a person, but a process.

STRATEGIES FOR IMPLEMENTATION, OR "WHAT DID WE LEARN ALONG THE WAY?"

Any new program is a work in progress, and as much was learned along the way about what did not work as about what was successful.

What Did Not Work?

RAW DATA

In the early stages of database development, monthly reports were created that summarized all activity for each team. The lengthy data were not in a user-friendly format and were difficult to read, let alone interpret. Over time, the data were formatted into meaningful reports that each team could use to make improvements.

EXPECTING STAFF TO CHANGE PROCEDURES WITHOUT A BUILT-IN ACCOUNTABILITY PIECE

As the program developed, procedures, protocols, and expectations also developed. As a change in protocol became necessary, it would be reviewed with staff and they would indicate understanding verbally. It was assumed then that because we had laid out our expectations, staff would implement the changed protocol. Later it was discovered that staff actually had difficulty incorporating the changes into their routine unless there was a method of accountability. For example, staff was asked to orchestrate brief multidisciplinary conferences on all patients who stayed longer than 7 days. The purpose was for the team to develop a patient-specific plan to help move the patient to the next lower level of medical care as appropriate. Although staff agreed in theory that this was a good idea, as the day got busy, this task was often overlooked. It was not until we instituted a form for documentation that could also be used for auditing purposes that we began to see compliance. The meetings began to be held regularly, resulting in better team planning for patient care.

LONG PRESENTATIONS TO ADMINISTRATION

In the beginning, elaborate presentations were prepared that demonstrated detail on significant programmatic outcomes. Meetings at upper administrative levels are so tightly packed with agenda that the point of the presentation was rarely reached before the allotted time expired. We learned that the presentations needed to be short and to the point and to “pack a punch.” Key outcomes were prepared for the presentation, with background information available only if asked.

What Did Work?

In retrospect, several strategies assisted administration to understand the validity and positive cost-effective program outcomes. There were also several that helped to break down the human barriers and resistance to change.

SELECTIVE USE OF E-MAIL

A summary email of important program outcomes sent to key administrators received more feedback than many other strategies. The e-mail listed in bullet form the specific program outcomes.

AWARDS LUNCHEONS

Twice a year, a luncheon was held to celebrate the successes of the program. Key administrators were invited, and awards were given for various team successes. Cases selected for recognition were complex, requiring teamwork, creativity, and skill to work toward a quality cost-effective patient outcome. Each team that received an award was given a certificate. In addition to providing recognition for a job well done, it provided a learning tool to demonstrate complex problem solving, as well as humor. For example, the “best travel agent” award was presented to the case manager who was able to negotiate with an employer for an airline ticket for a stroke patient who could not get home. A “Most Dollars and Days Saved” award was given to the neonatal case management team (physician, case manager, social worker, staff nurse, and parents) who worked with the payer in negotiating an early discharge for a premature baby. The payer was able to substitute additional home visits, allowing the parents to care for their baby at home instead of at the hospital. This saved 3 weeks of hospitalization and improved care for the baby by being at home.

SYSTEM ACCOUNTABILITY AND CONSISTENT STRUCTURE AND FEEDBACK

This was by far the most labor-intensive part of program startup. Assisting teams to learn the technical aspect of the job as well as make the internal changes necessary to work as a team proved to be a crucial

aspect of program development. Setting up how staff team behaviors could be measured, rated, and audited was time consuming but helped change behavior most effectively. Management time was spent on lots of one-on-one supervision on difficult cases, chart audits, feedback and encouragement, and helping staff compare data on a month-to-month basis. Currently, management staff makes weekly rounds, reviewing charts and giving immediate feedback to the triad teams.

MODELING BEHAVIOR

At first, each team required leadership presence at their quarterly meetings to model how to analyze and present their data. Eventually the case managers were able to assume the leadership function.

Anticipated Further Development

The program began as unit-based dyad teams to get the system up and running and to ensure that all patients received services. The program then transitioned to a more population-based triad model that serves inpatients and outpatients, providing for better continuity of care. The logistics of such a model are difficult. How does one team provide inpatient and outpatient care when outpatient clinics are spread all over the city? How do patients receive services if they do not fit into one of the team case-managed populations? An additional sophistication in the use of data and outcomes is anticipated. The data were first used to change internal system issues. It was hoped that the case management program would partner with the business contract development office. The data should be useful in procuring contracts for the health care institution.

With each change in the model, it is anticipated that the teams will move back into the stages of resistance to change. However, although the process of resistance to change remains the same, staff should deal with it at a less traumatic level because they are at a more sophisticated stage of team development.

Key Factors in Program Success

1. Pay strong attention to the human dynamics, as they are as crucial to program success as the model you choose. Human dynamics are the most labor-intensive part of new program development. It took 6 to 9 months before consistent behavior change occurred on the part of the teams.
2. The model must include consistent ongoing structure, accountability, and feedback to staff. Newly hired staff must be brought up to the same skill level as experienced staff.
3. Personnel skilled in database design are crucial. At first, a full-time person was available to enter data, develop report formats, and analyze the data. As data collection matured, the program was able to partner with the Quality and Outcomes Department for reports and analysis.
4. Develop baseline data with measurable outcomes to justify program viability. This contributes to morale, allowing staff to measure their contribution.
5. Market your program to your administrators, as well as internal and external customers.
6. Celebrate your successes to administration and to staff.

And remember that case management is a process, not a person!

Reference

Riippi, L., & Jackson, S. (1997). Case management finds success in a university hospital. *QRC Advisor*, 13(10):7-9.

The University of Colorado Hospital Psychiatric Service Health Case Management Model

*An Innovative Approach
to Client-Centered Care*

*Bari K. Platter
Bonnie Cox Young
Kay Vaughn*

Gambar dengan hak cipta

INTRODUCTION

Although ideas regarding the concept of case management have been present for decades (Tahan, 1998; Floersch, 2002), the advent of managed care in the 1980s has been a catalyst for the development of case management models (Baker & Giese, 1992; Sulman et al., 2001). In this era of managed care oversight, mental health systems have had to respond with major reform (RESPONSE, 1998; Sulman et al., 2001). The literature regarding psychiatric case management is scant and does not outline a comprehensive model that addresses the complexity of psychiatric clients (Baker & Giese, 1992; Forchuk et al., 2002; Sulman et al., 2001; Tempier et al., 2002; Thomas, Dubovsky, & Cox-Young, 1996; Thomas et al., 1996).

Because of managed care's insistence that clients be quickly reintegrated into the community, inpatient psychiatric staff can no longer exclusively focus on the microsystem of the hospital (Bedell et al., 2000; Krmpotic, 1992). Development of effective relapse and discharge plans has been one step toward addressing length-of-stay and quality-of-care issues. Another important piece has been the development and use of a treatment plan that drives forward treatment and helps emphasize variances in clinical care (Forchuk et al., 2002; Goode, 1995; Sulman et al., 2001).

Historically, economic concerns and societal views about the environment in which psychiatric clients should be treated have influenced the delivery of mental health services (Anthony et al., 2000; Bedell, 2000). Currently, the emphasis of mental health treatment is in keeping the client in the community and avoiding the restrictive and costly environment of the hospital. Because mental health systems have not clearly articulated an inpatient case management model, a comprehensive model includes orientation, training opportunities, and the development of professional standards (Forchuk et al., 2002; Sulman et al., 2001). In addition, competency demonstration, continuum of care design, and treatment plan development are equally important (Forchuk et al., 2002; Thomas et al., 1995). The literature advocates for input from consumers regarding evolution of the case management model (Samele et al., 2002; Tempier et al., 2002). Incorporation of customer satisfaction data is a component of addressing the need for frequent and continual evaluation of newly developing case management models (Vaughn, Cox-Young, Webster, & Thomas, 1997; Vaughn, Webster, Orahood, & Cox-Young, 1995; Webster, Vaughn, Webb, & Playter, 1995).

Recent literature also notes the need to discuss theoretical models of case management (Cohen & Cesta, 2001; Koenig, 2001; Michaels & Cohen, 2001). Nursing theory emphasizes the relationship between the caregiver and the client and adds a therapeutic element that can be incorporated into a successful case management model. Thoughtful decision-making concerning the underpinnings of theory that guide clinical practice must address the client, as central. Montgomery and Webster (1994) believe that brief forms of psychiatric care are congruent with nursing's metaparadigm. Brief therapy theories, assertive community treatment models, and family-centered interventions form the theoretical base of a holistic case management model. Ethical dilemmas of managing care must be addressed when developing a case management model. Basing clinical decisions solely on cost containment is unethical. Case managers (CMs) must position themselves to advocate for quality-of-care issues while speaking the language of business concerns of managed care companies. This type of treatment must be highly individualized so the client and family are actively involved in the treatment planning process (Anthony et al., 2000; Bedell et al., 2000; Samele et al., 2002; Tempier et al., 2002; Vaughn et al., 1997).

The UCHPS includes a philosophy in which the provision of efficacious and quality care is provided within the framework of not a day too long and not a day too short. This chapter outlines an innovative model of inpatient psychiatric case management that bridges the gap between the hospital and the community. This model specifically addresses the scope of practice, training, orientation, support, communication skills, treatment plan development, and macromanagement of the larger, real world environment of clients. Thoughtful integration of brief therapy approaches, family preservation techniques, and assertive community treatment models are deliberately combined to articulate a theoretical conceptualization of the UCHPS Case Management Model (Berg, 1991; De Shazar, 1991; Stein & Test, 1980; Test, 1992).

EVOLUTION OF THE UCHPS CASE MANAGEMENT MODEL

Early on, UCHPS recognized the need to respond to the demands of third party providers to offer efficient hospitalization (Webster et al., 1995). With the demand for cost-effective treatment, UCHPS leadership realized that we would have to make changes in our philosophy and purpose and the roles of interdisciplinary team members (Forchuk et al., 2002; Vaughn et al., 1995). The ethical dilemma we faced

was to provide efficient care without sacrificing quality. As other psychiatric programs struggled to shorten lengths of stay while continuing to use longer-term therapy modalities, we, on the other hand, explored theories that envisioned the client as the center of clinical decision-making. By reviewing the literature, we ascertained that solution-focused therapy, assertive community treatment, and family preservation models were most congruent with treating the client by focusing on their strengths and real world concerns (Berg, 1991; Stein & Test, 1980; Vaughn et al., 1997). In developing our continuum of care model, we applied principles of solution-focused therapy, assertive community treatment, and family preservation models to acute inpatient services (Vaughn et al., 1997). As length of stay continued to decrease and acuity increased, we quickly realized that close clinical coordination was essential to successful outcomes (Baker & Giese, 1992; Thomas et al., 1996). The role of the CM was developed: a clinical coordinator, responsible for driving treatment forward, maintaining a solution-focused approach with clients and their families, efficiently involving ancillary providers in treatment, documenting treatment plans and progress, and developing and maintaining close working relationships with third-party providers (Figure 10-1).

Due to fragmentation of the mental health system and the complexity of many of our clients, we developed a guideline by which to assign CMs to work with specific patients. This guideline describes

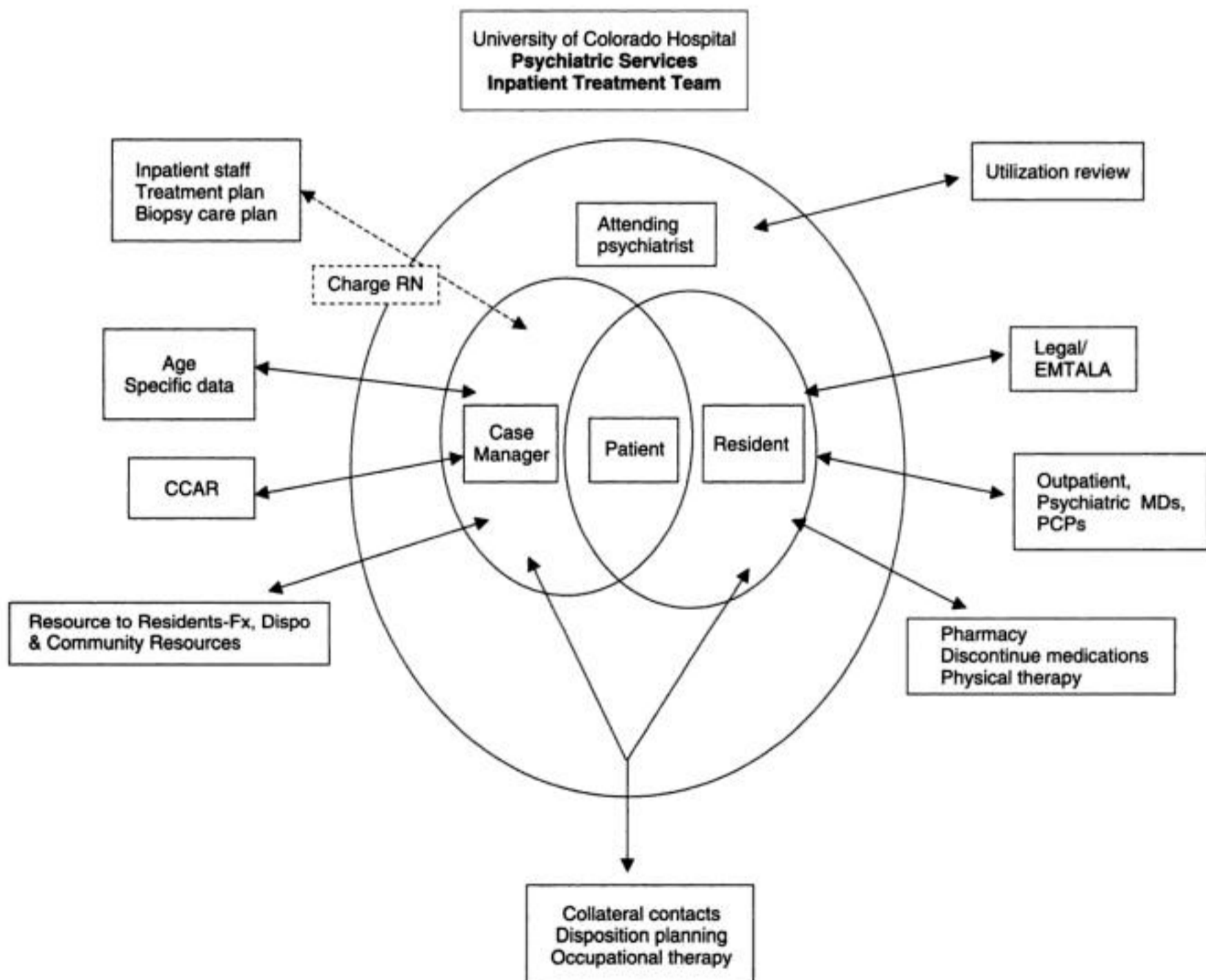


FIGURE 10-1 University of Colorado Hospital case management model.

patient conditions, psychosocial problems, and complex treatment issues that are seen as being highest risk. Decisions regarding development of this guideline were made after a review of the current literature (Bedell et al., 2000; Forchuk et al., 2002; King et al., 2002; Mehr, 2001, 2002; Sulman et al., 2001; Ziguras et al., 2002). This tool also assists the attending psychiatrist in identifying which patients will be followed by a CM.

The UCHPS Case Management Model was structured to ensure that the CM is able to smoothly guide the client and family through the care continuum (Vaughn et al., 1997). Unlike other case management models, we visualized the scope of this role as encompassing both internal inpatient and outpatient treatment as well as external community systems of care (Figure 10-2). Consistent with the assumptions of brief therapy, the UCHPS continuum of care includes the value of identifying the client's highest level of functioning, establishing treatment goals that incorporate what is working in the client's life, and, most important, returning the client to the community as the paramount goal of hospitalization.

When the UCHPS Case Management Model was first conceptualized, leadership discussed the parameters of the CM job description. Issues that led to development of the CM role included inconsistencies in the quality of treatment plans and a breakdown of communication between the treatment team and line staff. Because nurses are trained in the formulation of psychosocial/biomedical treatment plans and have direct knowledge of formal and informal communication patterns on inpatient psychiatric unit, we determined that a nurse would best fill the role of CM. Social workers were also determined to be important members of the treatment team, coordinating family work and discharge planning. Therefore, when the UCHPS Case Management Model was first implemented in 1990, each treatment team consisted of a nurse CM, a social worker, and an attending psychiatrist. The caseload of one treatment team included approximately five to eight inpatients. Nurse CMs and social workers managed two treatment teams, responsible for the care of a total of 10 to 16 patients.

The nurse CM's role included development of the treatment plans and implementation with the line staff; communication with ancillary services, such as occupational therapy, physical therapy, and pharmacy; coordination of follow-up appointments for medical problems; and utilization management (UM). The social worker's role was limited to providing family intervention and coordinating discharge planning. Social workers were discouraged from participating in discussions of milieu issues, and nurse CMs did

FIGURE 10-2 University of Colorado Hospital continuum of care model.

not discuss family systems issues. The nurse CM and the social worker met several times each day for clinical updates. Although there was consistency in the provision of care in this model, both the nurse CMs and the social workers were dissatisfied, seeing the model as fragmented and compartmentalized. The social workers complained that because they did not know many important details of the patient's treatment, it was difficult to keep the family and outpatient providers updated about the patient's progress. Nurse CMs felt left out of discussions about family and support system issues. As the psychiatric and medical acuity continued to increase, both groups experienced the system as inefficient and unsatisfactory.

To increase efficiency, positive outcomes, and job satisfaction, UCHPS leadership asked the nurse CMs and the social workers to make a list of job responsibilities. It quickly became apparent that the social worker's scope of practice was limited. The social workers, all experienced in inpatient psychiatry, were quite capable of competently performing many of the duties of the nurse CMs. Conversely, many of the nurse CMs had extensive experience with family and support system work. After many months of negotiating responsibilities, leadership decided that the roles of the nurse CM and the social worker could be combined to form the role of psychiatric CM. In this way, each psychiatric CM would have expanded responsibility for one treatment team (five to eight patients and their families) instead of two teams, as in the previous model.

To ensure a smooth transition from a model with the team consisting of a nurse CM, social worker, and attending psychiatrist to the new model of a psychiatric CM and an attending psychiatrist, both nurses and social workers met weekly over several months. In these meetings, members of each discipline exchanged detailed information about their own duties/responsibilities. When the CMs and leadership felt comfortable with the transition, new teams were formed. Each discipline made a commitment to be available to the other for professional consultation.

Having successfully negotiated this transition in provision of case management services, UCHPS faced a new challenge in 2002: balancing the fiscal concerns regarding case management with the need to provide structure and support for significantly ill patients. To achieve this balance, UCHPS leadership decided to assign case management by outlier, using a tool to assist in identification of high-risk and complex patients.

Although this chapter focuses on the provision of CM services in the inpatient setting, it is important to recognize that UCH has been able to adapt the UCHPS case management model to community settings. The UCHPS Community Service provides outpatient case management, which incorporates brief therapy, family preservation, and assertive community models. This team was developed in response to requests from public managed care systems to provide intensive home-based services for their clients. Team members work with families in their homes, providing case management, psychotherapy, and parenting education. The CMs in this setting, all licensed clinicians, work independently to provide care delivery. Formal group clinical supervision occurs once a week for 2 hours with a psychiatrist and a licensed marriage and family therapist. Clinicians also receive frequent formal and informal individual clinical supervision.

As the UCHPS continuum of care model evolved, so did the role of the CM. Because we conceptualized the CM role to be flexible and dynamic, resistance to change thus far has been minimized (Baker & Giese, 1992; Thomas et al., 1995). Leadership recognized that the complexity of this model could lead to role dissatisfaction and poor treatment outcomes. Thoughtful discussions concerning the educational needs of the CM led to the development of a competency-based orientation to the role, continued education and training, and development of ongoing clinical supervision. Although costly to our organization, orientation, training, and supervision programs are strongly supported by our administration. In the next section of this chapter, we discuss the six components of a successful case management model.

COMPONENTS OF A SUCCESSFUL CASE MANAGEMENT MODEL

Orientation

The process of clinical orientation at UCH is multidimensional. CMs participate in a competency-based, hospitalwide, department- and unit-specific orientation that includes didactic learning experiences and clinical orientation with a trained preceptor. Because CMs are responsible for both communicating the plan of care to the line staff and guiding treatment forward, they must have an understanding of the responsibilities of the line staff and an ability to develop treatment plans that clearly articulate line staff interventions for their patients. To clearly understand the role of line staff, CMs are oriented to milieu management and mental health worker and clinical nurse responsibilities.

Classroom orientation consists of 2 full days of lecture and didactic learning. An overview of UCH patient services programs and our performance improvement model is presented. A clinical nurse specialist with prescriptive authority teaches a 2-hour course about psychotropic medications and administers a competency performance examination to participants. The clinical nurse specialist/educator conducts a 1-hour risk assessment course and a 5-hour brief therapy course (Webster et al., 1995). A mental health worker with more than 15 years of inpatient psychiatry experience teaches a course about lower-level interventions in the milieu and behavior management. CMs must demonstrate competency in risk assessment, brief therapy approaches, and behavioral management before orientation is completed.

The clinical nurse specialist/educator meets with each CM orientee before the first clinical orientation day. CM orientees are given a packet called the "Competency Performance Orientation Checklist" (see Appendix 10-1). This packet includes competencies, both knowledge and skill based, that the CM must either understand or demonstrate before the end of the orientation period. The clinical nurse specialist/educator updates the checklist annually in response to changes in clinical practice and role responsibilities. Areas of competency reviewed in the checklist include utilization of brief therapy approaches, interdisciplinary communication, discharge/disposition planning, group and family therapy, therapeutic relationships, milieu management, policies and procedures, documentation guidelines, and mandatory safety procedures. All of the competencies are reviewed formally in classroom orientation and reinforced in clinical orientation with the assigned clinical preceptor.

The clinical nurse specialist/educator assigns a trained clinical preceptor to provide clinical orientation. During clinical orientation, which lasts 3 to 4 weeks, CM orientees first observe the clinical preceptor on the unit. The clinical preceptor reviews the Competency Orientation Performance Checklist with the CM orientee each morning, developing daily and weekly goals for clinical orientation. Typically, CM orientees begin some independent practice by the end of the first week of clinical orientation. At the end of the clinical orientation, the clinical nurse specialist/educator reviews each section of the completed Competency Orientation Performance Checklist with the CM orientee to ensure that the CM orientee feels comfortable to begin managing a caseload. If the CM orientee or the clinical nurse specialist/educator identifies deficits that must be addressed immediately, the clinical nurse specialist/educator can either choose to work directly with the orientee or ask the clinical preceptor to continue clinical orientation. Because the role of CM is so complex, leadership staff expects that most CMs will work approximately 6 months before they feel a sense of mastery in the position. This expectation is reinforced to new CMs, as many have stated that they feel pressure to "know it all" when clinical orientation ends. To allow new CMs to flourish in this complicated and multifaceted role, UCHPS leadership has organized extensive clinical supervision for this group.

Clinical Supervision

Because the CM's role as the hub of the treatment team is crucial for effective treatment, clinical supervision becomes essential for positive treatment outcomes. Historically, patient services staff have not received intense, ongoing clinical supervision, nor has this modality been valued (Forchuk et al., 2002; Sulman et al., 2001). Clarity of the supervision model to reinforce competency-based orientation came as leadership recognized the need to provide several modalities of supervision for CMs. Currently CMs participate in many formal and informal supervision activities. Professional role development, family supervision, and "behind the mirror" supervision are discussed.

PROFESSIONAL ROLE DEVELOPMENT

To support new CMs in integrating with treatment team members, they meet weekly with the Clinical Nurse Specialist/Educator to discuss role development issues. New CMs have struggled to successfully function in this complicated system and have voiced a need to meet with a knowledgeable mentor to discuss emerging role development issues. Areas of discussion include the UCHPS Case Management Model, UCHPS continuum of care model, high-risk cases, patient advocacy issues, and customer relations. Because the facilitator of this group is not a direct supervisor, new CMs are more apt to openly discuss barriers to role development. UCH leadership supports this costly intervention, because not to do so causes role ambiguity and may lead to implementation of incongruent philosophies of care. This group meets weekly for 1 hour.

FAMILY SUPERVISION

A key role of the CM is the provision of family and support system intervention. Level of competency in systems interventions varied, depending on the prior training and experience of the CM. Discrepancy in functional levels of the CM led to the need to have formalized supervision that acknowledged the expertise CMs brought to the role, while recognizing that deficits did exist. Because the training needs varied between disciplines, the clinical nurse specialist/educator and the lead social worker met to discuss the goals and format of the supervision.

In the family supervision "Case Presentation Outline" (Box 10-1), the CM's role is structured both to develop a professional case presentation and to facilitate a peer discussion. In the monthly family supervision meetings, CMs have presented a wide variety of cases. Issues have included transcultural intervention, multisystem coordination, countertransference issues, complex medical comorbidity, substance-abusing patients and family members, and how to successfully intervene with families with special needs. Initially, CMs were hesitant to give feedback to their peers. Because clinical supervision has not been consistently valued in inpatient psychiatric settings (Bedell et al., 2000; Forchuk et al., 2002), many CMs were not comfortable with and did not understand the concept of giving and receiving peer feedback regarding clinical performance. To model acceptable ways of giving and receiving feedback, the clinical nurse specialist/educator and the lead social worker presented the first two cases in family supervision.

BEHIND-THE-MIRROR SUPERVISION

Because brief therapy philosophy includes rapid mobilization of client's resources, supervision supporting this philosophy becomes essential in short-term hospitalization. The CM needs expertise in directing clinical care with families, support systems, and inpatient/outpatient staff. Behind-the-mirror supervision is a process by which CMs are able to receive immediate feedback from their peers and supervisors (Vaughn et al., in press). In behind-the-mirror supervision, CMs conduct individual interviews with patients and/or families using brief therapy modalities. The literature concerning clinical supervision suggests that the model should reflect the philosophy of patient care delivery

(Vaughn et al., in press). Therefore supervision is a parallel process whereby the supervision team provides the CM with feedback in the same structured format as used by the CM to give feedback to the patient/family. This process has been described in detail in previous articles (Vaughn et al., unpublished manuscript).

Interdisciplinary Team

Traditionally, inpatient psychiatric treatment has been coordinated by psychiatrists (Thomas et al., 1995). As third-party providers and other external systems have demanded shorter lengths of stay and more consistent communication of the patient's progression, psychiatrists have realized that it is imperative to share and delegate clinical and organizational functions (Baker & Giese, 1992; Thomas et al., 1995, 1996; Vaughn et al., 1997). Development and implementation of the UCHPS Case Management

Model would not have been successful if the medical staff had not first agreed to change the model of patient care delivery. Thomas et al. (1995) describe the process of redefinition of multidisciplinary team roles. They acknowledge that both attending psychiatrists and trainees initially had difficulty with the transition from a more traditional model of care delivery to the UCHPS Case Management Model. Their stance, however, is that clear role definition of the CM ensures “clinical efficiency” and will ultimately “optimize the use of the psychiatrist’s time.” Attending psychiatrists are oriented to the UCHPS Case Management Model by their peers. Support of the model is reinforced when new attending psychiatrists begin working on the units and see the positive effects of collaborative interdisciplinary working relationships. Residents in training and medical students are oriented to the UCHPS Case Management Model by senior CMs at the beginning of their clinical rotation. Attending psychiatrists and CMs formally and informally reinforce both the CM and resident roles with the residents and medical students during interdisciplinary meetings.

Treatment Plan

Clinical information is formally reviewed with the treatment team in daily multidisciplinary rounds and twice-weekly treatment planning meetings. The CM contacts treatment team members informally if there is new clinical information that must be reviewed immediately. The CM is responsible for leading treatment planning meetings and for integrating and documenting all clinical information in the patient’s treatment plan. The purpose of treatment planning meetings is to review new clinical information and to revise the plan of care. All of the treatment team’s patients are presented in 1 hour, giving the treatment team approximately 10 minutes to revise the plan of care for each patient. In-depth discussion regarding the psychodynamic formulation of the case is completed outside of the treatment plan meeting (Baker & Giese, 1992; Thomas et al., 1995).

CMs contact external providers to negotiate how clinical information will be exchanged. Telephone conferences, treatment update meetings, and discharge meetings are coordinated at the beginning of hospitalization, ensuring external provider participation. Examples of external treatment provider participation include outpatient CMs, group home staff, probation and parole officers, social services technicians, and clergy. The CM is responsible for establishing and maintaining contact with family and community supports of assigned patients. Family input is considered essential to successful treatment. Issues that appear to be part of the precipitating events of hospitalization are addressed in family meetings. Patient services staff meet every shift with the client to establish treatment goals and interventions. At the end of each shift, patient services staff document progress toward goal attainment and response to interventions. If the client cannot participate in problem solving because of cognitive impairment, the treatment team works with the family and community supports to develop goals to expedite restabilization. Patient services staff attend and participate in the treatment planning meeting, bringing up-to-date clinical information.

Treatment plans are structured to provide clear interventions for line staff and the multidisciplinary team. A performance improvement team reviews the treatment plans annually and makes appropriate revisions. This team is chaired by the Clinical Nurse Specialist/Educator, and group participants include an attending psychiatrist, patient services managers, a CM, a charge nurse, and a mental health worker.

An example of one of the UCH treatment plans is the “Suicide Attempt/Ideation” treatment plan (see Appendix 10-2). In the treatment planning meeting, the CM and the charge nurse are responsible for completing this form. The first part of the plan includes a brief formulation of the case and the psychiatric and medical diagnoses. The second section of the treatment plan documents measurable goals. Goals are developed with input from the treatment team, line staff, patient, family, and support

system (Webster et al., 1994). Next, interventions are addressed. Interventions associated with providing safety (risk assessment and suicide precautions) for the patient and the milieu are listed first. Other interventions include laboratory testing and consultation, medication regimen and administration, medication and illness education, group participation, family and support system interventions, discharge planning issues, and treatment of acute medical issues. The last section of the treatment plan is the outcome section. In this section the treatment team identifies what the functioning level of the patient must be before the patient is discharged.

After the treatment planning meeting is completed, the CM and charge nurse are responsible for ensuring that the line staff implements the interventions outlined in the newly revised plan. Other treatment plan forms that the CM may use to develop a complete plan of care include the "Behavioral Care Plan" and "Take Care of Yourself" (see Appendix 10-3). The Behavioral Care Plan guides the line staff in behavioral interventions aimed at providing the patient with the external structure he or she needs to stay in behavioral control on the unit. The Take Care of Yourself form is completed by the CM with input from the outpatient provider. The outpatient provider gives the CM information about the client's cognitive and functional ability to complete activities of daily living (ADLs). With this information the CM completes the form, giving the line staff detailed information about level of assistance with ADLs and how often ADLs should be completed. Because it is often difficult to assess the client's cognitive and functional ability during a short hospital stay, it is important to provide care that is consistent with the care provided in the community setting. If the level of assistance provided is consistent between inpatient and outpatient providers, the client is less likely to demonstrate symptoms of regression after discharge.

Use of treatment plans is not a new concept; most medical inpatient units use critical pathways and/or care maps to structure clinical intervention and to provide standardized outcome measures (Cohen & Cesta, 2001; Goode, 1995). In psychiatry, where complex psychosocial and environmental variables influence the client's clinical progress, measuring outcomes and accounting for variances in length of stay are challenging and have not been well documented (Baker & Giese, 1992; Thomas, Dubovsky, & Cox-Young, 1996; Thomas et al., 1996, 1997).

Variance tracking within mental health systems is sadly at a rudimentary stage of development. UCHPS has contributed to the development of variance tracking by collecting both inpatient and outpatient outcomes data in conjunction with managed care companies (Baker & Giese, 1992; Thomas, Dubovsky, & Cox-Young, 1996; Thomas et al., 1996, 1997).

In the infancy of psychiatric managed care, CMs partnered with managed care providers to develop UM tools that measured length of stay, recidivism, successful suicides, and readmission within 24 hours (Baker & Giese, 1992; Thomas, Dubovsky, & Cox-Young, 1996; Thomas et al., 1996, 1997). As we developed partnerships with an increasing number of managed care companies, the time expenditure required of CMs to perform UM duties began to take away from important clinical responsibilities.

Utilization Management

In June 1999 a social worker was hired for the specific purpose of completing inpatient UM processes. Before this time, CMs were responsible for all authorizations for clients on their caseload. It became evident that the focus of client care was being negatively affected by this UM function. As the UM process became more complicated, it also became more time consuming; CMs had an increasingly difficult time completing other clinical duties. UM inherently involves a great deal of telephone work; unless the CM is readily available to answer telephone calls, an inordinate amount of time is spent brokering authorizations for continued treatment. Before changing our UM system, the rate of successful authorization for treatment was 50%. Lack of authorizations for treatment created difficulty in

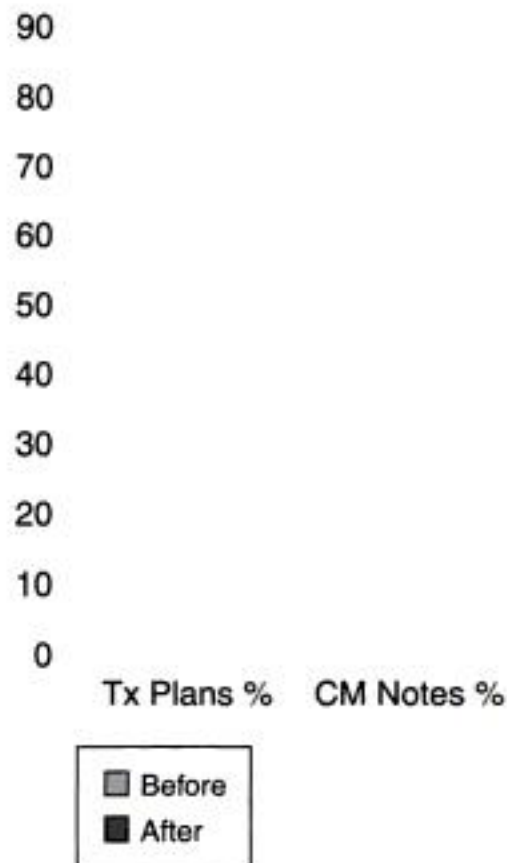


FIGURE 10-3 Comparison of completion rates of treatment plans and case management progress notes before and after utilization review was separated from case management responsibilities.

hospital billing and collections. On the clinical front, the quality of CM documentation decreased and quality of treatment plans was insufficient, secondary to emphasis on the time-consuming task of UM (Figure 10-3).

The decision to allocate resources to UM has had several positive outcomes. The rate of successful authorization improved dramatically. There is increased flexibility in the CM's schedule. The UM process now interfaces with finance and billing departments. There is an organized, careful review and response to denials. The UM staff member generally works independently but consults with CMs when there are complex clinical issues that require additional input for authorization for treatment. The UM/utilization review staff member reviews all cases regardless of health care coverage using InterQual standards (McKesson, 2002). All cases with a length of stay greater than 14 days are reviewed with the interdisciplinary treatment team. Any identified quality concerns are reported to the program manager. The UM position works closely with the Admissions Department to recommend benefits acquisition, financial counseling, and assistance with gathering insurance information.

Customer Satisfaction

Customer satisfaction has long been viewed as an important indicator of quality of care (Anthony et al., 2000; Caslyn et al., 2002; Goode, 1995; Samele et al., 2002; Tempier et al., 2002). In this age of increased managed care, third-party providers, and regulatory agency oversight, customer satisfaction data carry more weight (Baker & Giese, 1992). At UCH, we have always maintained that patient satisfaction is the most important indicator of our clinical success. Valuing customer satisfaction meshes solution-focused philosophy with our model of care delivery. In solution-focused therapy, core concepts include the belief that clients have the best answers for their problems and that they should always be involved with formulating treatment goals and evaluating treatment outcomes

(Vaughn et al., 1997). We firmly believe that successful evolution of our model depends on client input.

In 1990 we began to gather customer satisfaction data. We used these data to determine educational needs for line staff and program redesign. In 1996 we began to participate in a national patient satisfaction benchmarking program, RESPONSE Healthcare Information Management, Inc. This enabled us to compare our customer satisfaction data with similar psychiatric facilities across the nation. UCHPS data indicate that across categories we met or exceeded the national benchmark (RESPONSE, 1998) (Figure 10-4).

As indicated in Figure 10-4, the areas of greatest customer satisfaction were in teamwork among staff, respect shown and dignity maintained, overall quality of care and services, outcome of care, discharge instructions, and coordination of care after discharge. In completing the customer satisfaction questionnaire, clients are encouraged to provide comments regarding their treatment.

“I realize that most of what needs to be done to help myself needs to come from me.” UCHPS inpatient, 1998

Clients frequently note how useful the treatment experience has been for them, that the staff gave them confidence to succeed, and that they were involved with treatment decisions.

Currently UCH participates in a national benchmarking program by Press, Ganey Associates, Inc. (2003). Current results from this national program are available online and are regularly reviewed with all staff. This process allows CMs to receive feedback about their role and gives them an opportunity to participate in the dynamic process of performance improvement.

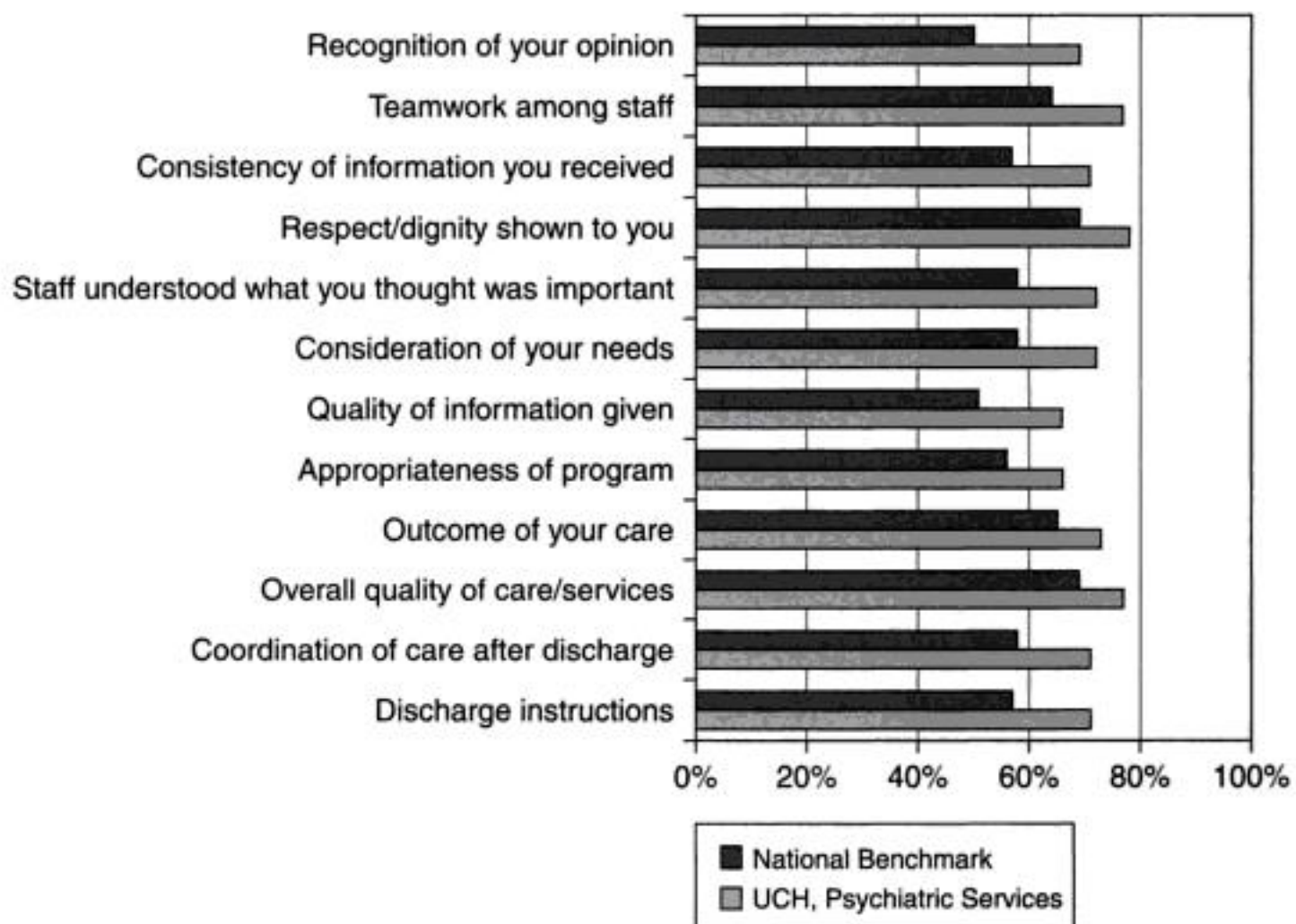


FIGURE 10-4 Percentage of responses from the “very good” to the “excellent” range. Data were compiled from *National Benchmark Report, Psychiatric Hospitals (1998)* and *RESPONSE (1998)*.

SUMMARY

In this chapter, we have outlined an innovative psychiatric case management model. We hope that our model adds to the paucity of information currently available regarding psychiatric case management models. Part of our success has been attributable to the support of UCHPS leadership, who back expensive orientation, training, and supervision aspects. Theoretical underpinnings that hold the client as central to successful treatment have remained the cornerstone of our success. Evolving treatment plans and UM processes reflect our desire to address our rapidly changing health care system. It remains important to evaluate new and innovative approaches in case management (Bedell, et al., 2000). Emerging programs include self-case management (Lieberman & Kopelowicz, 2002) and new approaches in case management of patients who have borderline personality disorder (Nehls, 2001).

Changes in clinical systems are occurring so rapidly that they outstrip the meager empirical data used to make changes in health care delivery models. Our hope is that psychiatric programs will band together to collect essential data regarding clinical variance, clinical outcomes, lengths of stay, and diagnosis-specific critical pathways. Outcome measures are particularly critical because psychiatric inpatient case management is new and relatively unstudied. Formal research projects are required to address the specific needs of various psychiatric populations.

References

- Anthony, W.A., Cohen, M., Farkas, M., & Cohen, B.F. (2000). Clinical care update: The chronically mentally ill case management—more than a response to a dysfunctional system. *Community Mental Health Journal, 36*(1), 97-106.
- Baker, N.J., & Giese, A.A. (1992). Reorganization of a private psychiatric unit to promote collaboration with managed care. *Hospital and Community Psychiatry, 43*(11), 126-129.
- Bedell, J.R., Cohen, N.K., & Sullivan, A. (2000). Case management: The current best practices and the next generation of innovation. *Community Mental Health Journal, 36*(2), 179-194.
- Berg, I.K. (1991). *Family preservation: A brief therapy workbook*. London: BT Press.
- Caslyn, R., Morse, G.A., Klinkenberg, W.D., Yonker, R.D., & Trusty, M.L. (2002). Moderators and mediators of client satisfaction in case management programs for clients with severe mental illness. *Mental Health Services Research, 4*(4), 267-275.
- Cohen, E.L., & Cesta, T.G. (2001). Within-the-walls case management: A acute care-based nursing case management model. In *Nursing case management from essentials to advanced practice applications*, 3rd edition, St. Louis: Mosby.
- De Shazer, S. (1991). *Patterns of brief family therapy*. New York: Guilford Press.
- Floersch, J. (2002). *Meds, Money, and Manners: The Case Management of Severe Mental Illness*. New York: Columbia University Press.
- Forchuk, C., Ouwerkerk, A., Yamashita, M., & Martin, M. (2002). Mental health case management in Canada: job description analyses. *Issues in Mental Health Nursing, 23*, 477-496.
- Goode, C. (1995). Impact of a care map and case management on patient satisfaction, and staff satisfaction, collaboration and autonomy. *Nursing Economic, 13*(6), 337-348.
- King, R., Yellowlees, P., Nurcombe, B., Spooner, D., Sturk, H., Spence, S., & LeBas, J. (2002). Psychologists as mental health case managers. *Australian Psychologist, 37*(2), 118-122.
- Koenig, E. (2001). Collaborative models of case management. In E.L. Cohen & T.G. Cesta (Eds.), *Nursing case management from essentials to advanced practice applications*, 3rd edition, St. Louis: Mosby.
- Krmpotic, D. (1992). Successful implementation of case management. *Nursing Connections, 5*(2), 49-50.
- Lieberman, R.P., & Kopelowicz, A. (2002). Rehab rounds: Teaching persons with severe mental disabilities to be their own case managers. *Psychiatric Services, 53*, 1377-1379.
- McKesson Health Solutions, LLC. (2002). *InterQual Level of Care Criteria*. Marlborough, Mass.: McKesson Health Solutions, LLC.
- Mehr, J. (2001). Case management: A review with implications for services for concurrent severe mental illness and alcoholism or substance abuse. *Psychiatric Rehabilitation Skills, 5*(1), 80-107.

- Michaels, C., & Cohen, E.L. (2001). Two strategies for managing care: Care management and case management. In E.L. Cohen & T.G. Cesta (Eds.), *Nursing Case Management from essentials to advanced practice applications*, 3rd edition, St. Louis: Mosby.
- Montgomery, C., & Webster, D. (1993). Care and nursing's metaparadigm: Can they survive in the era of managed care? *Perspectives in Psychiatric Nursing*, 29(4), 5-12.
- Montgomery, C., & Webster, D. (1994). Caring, curing and brief therapy: A model for nurse-psychotherapy. *Archives of Psychiatric Nursing*, 8(5), 291-297.
- Nehls, N. (2001). What is a case manager? The perspective of persons with borderline personality disorder. *Journal of the American Psychiatric Nurse's Association*, 7(1), 4-12.
- Patient Satisfaction Survey (1998). RESPONSE. Baltimore, Md.: Healthcare Information Management, Inc.
- Press, Ganey Satisfaction Measurement (2003). South Bend, Indo: Press, Ganey Associates, Inc.
- Samele, C., Gilvarry, C., Walsh, E., Manley, C., van Os, J., & Murray, R. (2002). Patient's perceptions of intensive case management. *Psychiatric Services*, 53, 1432-1437.
- Stein, L.I., & Test, M.A. (1980). Alternative to mental hospital treatment. I: Conceptual model, treatment program, and clinical evaluation, *Archives of General Psychiatry*, 37, 392-397.
- Sulman, J., Savage, D., & Way, S. (2001). Retooling social work practice for high volume, short stay. *Social Work Health and Mental Health*, 34(3-4), 315-332.
- Tahan, H. (1998). Case management: A heritage more than a century old. *Nursing Case Management*, 3(2), 55-60.
- Tempier, R., Pawliuk, N., Perreault, M., & Steiner, W. (2002). International report. Satisfaction with clinical case management services of patients with long-term psychoses. *Community Mental Health Journal*, 38(1), 51-59.
- Test, M.A. (1992). Training in community living. In R.P. Lieberman (Ed.), *Handbook of psychiatric rehabilitation*. New York: Macmillan.
- Thomas, M.R., Dubovsky, S.L., & Cox-Young, B. (1996). Impact of external versus internal case managers on hospital utilization. *Psychiatric Services*, 47(6), 593-595.
- Thomas, M.R., House, R., Shore, J., & Cox Young, B. (1995). The impact of economic and health care delivery changes on psychiatric residency training. Adapting to the new realities for clinical services and residency education in managed care. *Proceedings of the AACPD/RTD Conferences*, Baltimore, Md.: Department of Psychiatry, University of Maryland School of Medicine.
- Thomas, M.R., Kassner, C.T., Fryer, G.E., Giese, A.A., Rosenberg, S.A., & Dubovsky, S.L. (1997). Impact of shorter lengths of stay on status at discharge in bipolar mania. *Annals of Clinical Psychiatry*, 9(3), 139-143.
- Thomas, M.R., Rosenberg, S.A., Giese, A.A., Dubovsky, S.L., & Shore, J.H. (1996). Shortening length of stay without increasing recidivism on a university-affiliated inpatient unit. *Psychiatric Services*, 47(9), 996-998.
- Vaughn, K., Cox-Young, B., Webster, D.C., & Thomas, M.R. (1997). Solution-focused work in the hospital. A continuum-of-care model for inpatient psychiatric treatment. In S.D. Miller, M.A. Hubble, & B.L. Duncan (eds.). *Handbook of solution-focused brief therapy*. San Francisco: Jossey-Bass Publishers.
- Vaughn, K., Hastings-Guerrero, S., & Kassner, C. (1996). Solution-oriented inpatient group therapy. *Journal of Systemic Therapies*, 15(3), 1-13.
- Vaughn, K., Webster, D.C., Orahod, S., & Cox-Young, B. (1995). Brief inpatient psychiatric treatment: Finding solutions. *Issues in Mental Health Nursing*, 16, 519-531.
- Vaughn, K., Webster, D.C., Platter, B., Playter, A., & Webb, M. (Unpublished manuscript.). Solution oriented hospital practice and supervision: Building psychiatric nursing competencies. *Perspectives in Psychiatric Care*.
- Webster, D.C., Vaughn, K., & Martinez, R. (1994). Introducing solution-focused approaches to staff in inpatient psychiatric settings. *Archives of Psychiatric Nursing*, 8(4), 254-261.
- Webster, D.C., Vaughn, K., Webb, M., & Playter, A. (1995). Modeling the client's world through solution-focused therapy. *Issues in Mental Health Nursing*, 16(6), 505-518.
- Ziguras, S.J., Steuart, G.W., & Jackson, A.C. (2002). Assessing the evidence on case management. *The British Journal of Psychiatry*, 181, 17-21.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Utilizes brief therapy in individual, group, family, and milieu therapy

Evaluation Criteria

1. Verbalizes value system of long- and short-term therapist.
2. States the assumptions of solution-oriented therapy.
3. Verbalizes obstacles and pitfalls to avoid in brief therapy.
4. Reads brief therapy manual.
5. Has 1:1 interactions with patients, families, and support systems using solution-focused therapy and other brief therapy approaches.
6. States factors that contribute to regression in hospitalized patients.
7. Demonstrates use of reframing techniques.
8. States types of interviewing techniques used in solution-focused therapy and other brief therapy approaches.
9. Sets goal with patients, families, and support systems that are client centered, achievable, and measurable.
10. Attends solution-focused therapy and change theory orientation class and demonstrates competency through passing post-test with score of 80% or greater.
11. Attends monthly “behind the mirror” supervision sessions, participating as the clinician and as part of the supervision team.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Complies with hospital policies outlining documentation requirements

Evaluation Criteria

1. Completes treatment plan and ensures patient services implementation of treatment plan (including biophysical, psychosocial, and environmental realms).
2. Completes "Behavior Plan" with patient services staff input when applicable; used to address behavioral issues of assigned patients.
3. Completes "Take Care of Yourself" with patient services staff input when applicable; used to address self-care issues of assigned patients.
4. Documentation on the patient record is legible, accurate, and concise.
5. Completes 2-hour RN/LSCW reassessment forms in compliance with "Psychiatric Use of Seclusion and Restraint" policy.
6. Completes risk assessment on the Suicide Risk Assessment and Violence Risk Assessment forms, documents clearly in the chart, and communicates results with treatment team. Repeats this process as indicated, based on patient presentation.
7. Completes case manager section of the discharge plan form. Ensures that an RN has completed the RN section of the form before the patient is discharged.
8. Completes or describes the AMA discharge procedure.
9. Ensures completion of patient teaching standards for medication, diagnosis, and other educational issues.
10. Completes case manager progress note, minimum of 1 per week.

Ensures completion of psychosocial data base (childhood and developmental history, cultural issues, living arrangements, military history sections) and signs encounter form signature log.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Discharge planning

Evaluation Criteria

1. Ensures appropriate transportation is arranged for patient.
2. Clarifies patient's ability to take passes and makes necessary arrangements.
3. Coordinates/leads staffings with outpatient providers.
4. Arranges appropriate psychiatric/medical and other outpatient follow-up.
5. Coordinates/secures appropriate housing at discharge.
6. Educates patient, family, and support system about patient's current medication regimen and ensures that all understand the information presented.
7. Educates patient, family, and support system about how to secure financial resources.
8. Arranges facility transfers as indicated: coordinates completion of EMTALA forms.
9. Ensures completion of paperwork for nursing home placement.
10. Coordinates legal issues, such as legal status on the unit and legal issues in the community.
11. Is a liaison for community resources.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		<p>Orientee Date</p> <p>Preceptor Date</p>

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Interdisciplinary communication

Evaluation Criteria

1. Demonstrates interdisciplinary communication and coordination with medical staff, students, line staff, occupational therapy pharmacy, family medicine, internal and external consultants, patient representative, and others.
2. Demonstrates and documents appropriate sign-out of cases for planned absences from the unit.
3. Demonstrates appropriate sign-out of cases for unplanned absences.
4. Demonstrates ability to manage complaints related to assigned patients and involves the use of appropriate resources.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Establishes therapeutic relationships with patients and families

Evaluation Criteria

1. Reads and signs policy on confidentiality and therapeutic relationships.
2. States principles of therapeutic interactions.
3. Verbalizes difference between therapeutic and social relationships.
4. Reads policy on therapeutic relationships.
5. Reads guideline for staff/patient and family interactions.
6. States how age, race, gender, and culture of patient and family may affect therapeutic relationship.
7. States importance of terminating the therapeutic relationship with the patient and the family when the patient is discharged.
8. Reads adolescent and geriatric manuals and provides age-appropriate care.
9. Attends and participates in monthly family supervision meetings.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		<p>Orientee Date</p> <p>Preceptor Date</p>

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Provides and maintains a safe therapeutic environment

Evaluation Criteria

1. States five therapeutic aspects of milieu treatment.
2. Verbalizes difference between traditional inpatient milieu therapy and brief milieu therapy.
3. Verbalizes safety issues in the milieu.
4. Verbalizes hierarchy of interventions in the milieu.
5. Demonstrates use of lower level interventions in the milieu.
6. Verbalizes age-appropriate limit setting in the milieu.
7. Initiates search procedures as indicated.
8. States procedure when patients go AWOL.
9. Attends behavior management class and demonstrates competency by passing the seclusion/restraint test and the behavior management test with scores of 80% or better.
10. Demonstrates safe application of mechanical restraints.
11. Communicates with family and support system about the criteria/procedures for seclusion/restraint and maintenance of a safe milieu.
12. Supports family and support system by maintaining close contact with clinical updates and reassurance when patient is in seclusion/restraint.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Co-leads group therapy/family therapy/case conferences

Evaluation Criteria

1. Able to assess and address family dynamics and intervene using brief therapy and systems theory interventions.
2. Formulates the psychosocial focus of the acute care episode with the treatment team.
3. Educates the family and support system about the patient's medications, illness, and treatment needs.
4. Negotiates treatment goals and follow-up plans with the patient, family, and support system.
5. Applies new knowledge in family and support system intervention from monthly family supervision group to clinical practice.
6. Understands expectation of participation in ongoing educational activities that address family and support system intervention.
7. Verbalizes difference between group process and content.
8. Reads guideline on co-therapist before and after group conference.
9. Verbalizes effective and ineffective group therapist language and behavior.
10. Reads group therapy manual.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		
				Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

University of Colorado Hospital Psychiatric Services

COMPETENCY PERFORMANCE ORIENTATION CHECKLIST—PSYCHIATRIC CASE MANAGER

Name:

Competency: Complies with standards of job description

Evaluation Criteria

1. Verbalizes the three missions of UCH and vision statement.
2. Reviews the UCH organizational chart.
3. Reviews the UCH quality management plan and participates in performance improvement projects.
4. Reads and signs job description.
5. Participates in weekly professional role development group with the clinical nurse specialist/educator.

Preceptor/Educator			Comments	I Have Satisfactorily Performed the Above Competency
Taught	Performed with assistance	Performed independently		Orientee Date Preceptor Date

Courtesy University of Colorado Hospital, Denver, Colorado.

Multidisciplinary Treatment Plan

Suicide: Attempt/Ideation

DATE _____ Next Staffing _____

Privileges _____ Legal status _____ ELOS _____

DIAGNOSIS _____

Focus: Behavior Management: Self-Harm Related to:

- Psychosis Depression Panic Hopelessness Chronic illness
 Terminal illness Altered cognitive status Grief/loss _____
 Psychoactive substances _____ _____

Illustrated by:

- Suicidal ideation with a plan _____
 Suicide attempt _____

Goals (must be measurable):

- Patient will demonstrate ability to manage symptoms.

Interventions

1. Risk assessment (discipline responsible/frequency) _____
 2. SUICIDE PRECAUTIONS
• Assess and document suicidal ideation every shift • Must be RTW and on escape precautions • 15-minute safety checks • Patient searched and placed in hospital gowns
• Patient to remain in public areas on the unit during waking • MD note daily regarding continued suicide risk • Controlled items with staff supervision only
 3. Labs/Procedures/Medical Consults:

 4. Medications prescribed (list medications and dosages):

 5. Administer medications as prescribed and document response
 6. Medication education (as tolerated) to:
 Patient Family Outpatient providers _____

7. Patient to receive education or instruction on:
 Diagnosis Symptom management Substance abuse
 Stress management _____
8. Assess/scale current level of hopefulness
9. Patient to identify ways to increase hopefulness
 Symptom management plan Continue to scale hopefulness
 _____ _____
10. Patient to attend groups as appropriate (list groups):
 _____ _____
 _____ _____
11. Administer assessment tools (indicate frequency/discipline responsible):
 MMSE _____ _____
 Beck _____
12. Assess and document symptoms of psychosis (include confusion, disorganization)
13. OT consultation (indicate type): _____
14. Case manager or designee to:
 Gather collateral data
 Communicate with outpatient system regarding patient progress and discharge planning
 Assess and document level of family involvement
 Document discharge staffing/discharge family meeting

15. Diet _____
16. Acute medical issues and interventions _____

Outcomes

The patient demonstrates increased ability to maintain safety, as evidenced by:

- Decreased Beck score
 Increased GAF
 Symptom management plan in place
 Increased hopefulness

I have discussed the above treatment plan with my treatment team

Patient signature

Staff signature

Behavioral Care Plan

Date _____

Warning signs:

Expectations of behavior:

Interventions:

Positive reinforcers:

Patient signature

Date

Staff signature

Date

University of Colorado Hospital
Psychiatric Services
MR#1500.222
6/02 BP

Date: _____

Take Care of Yourself

Levels

- 1—Independent
- 2—Prompting
- 3—With assistance
- 4—Need 2 for assistance
- 5—Total care

Level of Assistance

	Frequency	Levels of Assistance	Explanation/Re-Evaluation
Shower			
Meals & fluids			
Deodorant			
Dress			
Mouth care			
Hair care			
Make bed			
Laundry			
Tidy room			
1:1			
Meds			
Group			
Other			

Behavioral Plan:

I understand that I am in the hospital to focus on _____

I agree to do these things to achieve my goal _____

Staff agrees to help me by _____

Patient signature _____

Staff signature _____

Beyond-the-Walls Case Management

Gambar dengan hak cipta

COMPELLING FORERUNNER: NURSING CASE MANAGEMENT ACROSS CARONDELET'S CONTINUUM OF CARE

*Cathy Michaels and Gerri Lamb
(adapted for this edition by Elaine Cohen)*

Carondelet Health Care: A Network of Nurse Partnerships and Care Coordination Strategies

During the past 10 years, nursing case management and other nursing partnerships have evolved that prepared Carondelet St. Mary's Hospital & Health Center, Tucson, Arizona, for the managed care environment. In 1985, at the onset of nursing case management beyond the walls of Carondelet, this facility began developing nurse partnerships to assist people at varying levels of risk to manage their health care. Initially, nurse case managers partnered across time and across health care settings with people at high risk. Then nurse practitioners, together with other nurses and staff from other disciplines, partnered with people at moderate risk in nurse-managed and neighborhood-accessible community health centers.

Based on Carondelet's experience of creating and maintaining integrated services of nursing case management and home health, respite, and home infusion therapy (Burns, Lamb, & Wholey, 1996; Michaels, 1991), Carondelet was selected as one of the four national demonstration sites for the Health Care Financing Administration (HCFA)-funded Community Nursing Organization, a risk-adjusted, capitated, nurse-managed ambulatory system of care. In this research program, Carondelet provided nurse partnerships and nurse-authorized services to Medicare enrollees at high, moderate, and low risk. Carondelet offered a system of care coordination and case management.

Evolution

Carondelet's model of professional nursing case management evolved from a decentralized home care program and nursing network that provided a multitude of services in a variety of settings (Ethridge, 1987, 1991; Ethridge & Lamb, 1989). The services available in the original system included acute or inpatient care, long-term extended care, home health care, and hospice, rehabilitation, primary prevention, and ambulatory care (Ethridge, 1991; Ethridge & Lamb, 1989). Nursing case management reduced the fragmentation associated with preadmission assessment, discharge planning, postdischarge follow-up, and hospital readmission (Health Care Advisory Board, 1990). The foundation for this work was partnership based on mutual respect. By helping people to understand the relationship between the choices they made and the consequences of their actions, nurse case managers not only translated the illness experience into learning about self and others but also acknowledged the patient as responsible for outcomes and the nurse for facilitating the process. In this regard, Carondelet nursing case management was one of the first models to relate practice to nursing theory, specifically Newman's Health as Expanding Consciousness (Newman, Lamb, & Michaels, 1991).

Two areas of evaluation predominated: the benefit of partnership and the impact of that partnership on use of hospital services. Qualitative findings supported a strong base in the nurse case manager-client relationship (Lamb & Stempel, 1994; Newman et al., 1991). Quantitative evaluation demonstrated reduced hospital use. The nursing case management process of assessing, coordinating, planning, and monitoring through partnership reflected appropriate use of medical intervention technology, reduced severity of illness when hospitalization was required, subsequent decreases in bed days, and increased accessibility to hospital alternatives (Ethridge, 1991; Ethridge & Lamb, 1989; Health Care Advisory Board, 1990).

Building on the success of this service, Carondelet established a nursing health maintenance organization (HMO) to provide health care and support services to elderly, chronically ill, and disabled individuals within a Medicare Senior Plan Contract (Ethridge, 1991; Michaels, 1991, 1992). If considered high risk, enrollees in this senior plan received integrated, community-focused nursing services, specifically, nursing case management and home health, respite, and home infusion therapy. Enrollees who did not match the high-risk profile were often referred to the Carondelet Community Health Centers for health monitoring, teaching, and care coordination. Overall, hospital bed days for the high-risk senior enrollees were significantly reduced (Burns et al., 1996), and enrollees served expressed high levels of satisfaction.

In 1992 Carondelet was selected as one of the four national sites to establish a Community Nursing Organization. A 3-year program funded by HCFA, the Community Nursing Organization is a research program based on experimental design. Indeed, the first outcome for this program was meeting the enrollment targets of 2000 in the experimental program called the Healthy Seniors Program and 1000 in the control group.

Carondelet's initial nursing HMO experience focused on people at high risk for managing their health care; the Healthy Seniors Program offers enrollment to Medicare beneficiaries whatever their risk for managing their health. Hence, nurse partnerships were established for enrollees at low, moderate, and



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.



You have either reached a page that is unavailable for viewing or reached your viewing limit for this book.

The new edition of a classic case management guide!

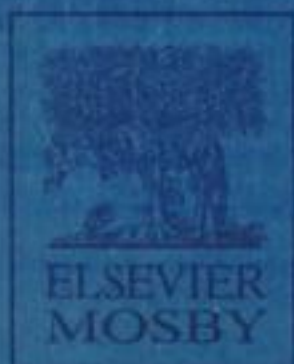
This practical resource, written by foremost experts in the field of case management, features complete coverage of every aspect of nursing case management, from its evolution and history to the latest case management models.

The new, fourth edition has been completely updated and is designed to help you prepare, implement, and evaluate a case management program within the framework of today's health care environment.

Inside you'll find:

- **Four new chapters**, featuring detailed information on hot topics such as
 - Revenue cycles covered in **Case Management: Life at the Intersection of Margin and Mission**
 - Emerging technologies covered in **Telehealth Applications for Case Management**
 - Straightforward explanation of Medicare procedures covered in **Maximizing Reimbursement through Accurate Documentation and Coding**
 - Strategy maps and balanced scorecards covered in **Effective Management Tools for Case Management Leaders**
- The latest information on **HIPAA regulations, patient safety, confidentiality issues, utilization management, and Medicare**
- Coverage of **proven case management models** currently being used in institutions across the country, including collaborative health care, acute care, and community-based case management models
- Discussions of current **political, legislative, and socioeconomic factors** affecting case management in nursing
- **Key insights, experiences, and advice** from nursing administrators who have researched and successfully implemented nursing case management in various facilities

Recommended
Shelving Classification
Case Management



www.elsevierhealth.com

ISBN-13: 978-0-323-02765-6
ISBN-10: 0-323-02765-2



9 780323 027656

Bahan dengan hak cipta