Case Management Leadership in -Transition of Care

Leading the team to improve

The Patient Experience

Clinical & Financial Outcomes

The Case management Value

The Physicians Engagement

Your Presenter:

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- Past Commissioner & Board Chair
- Commission for Case Management Certification (CCMC)

Goals

- Indicate the leadership role Case managers play in the development of a transition of care plan.
- Identify management tools designed to assist in developing a comprehensive assessment, POC and transition of care (TOC) plan
- Understand approaches to communicating with all team members to reach common goals outlined in a multi-disciplinary approach.
- Discuss ways of integrating UM/CM into all team member's workflow
- Learn "tricks of the trade" and situations where they're applied

Who Are We?

Case Managers hold clinical accountability and fiscal responsibility within their scope of practice;

- *UM
- *POC
- *TOC
- *Advocacy

Definition of Case Management

- Case management is a constant mindset and **professional obligation** for all clinicians. It is a deliberate patient and family centered **multidisciplinary partnership** that aims to facilitate an improved patient experience and effective and efficient management of cost. Case managers **proactively promote** preventative care and **advocate** and **facilitate** access to health services while continuing to meet fiscal responsibilities.

What CM/UM Can Do

Highlight your value. Show how CM decreases the teams burden on workload

Good CM = effective coordinated care.

Show the team outcomes

- Quality
- Focus on correct and timely status
- Reduce readmits
- Improved patient experience scores
- Financial
- Denial reduction
- Documentation accurate, timely SBAR
  - Active education
  - Passive education
  - Focused feedback

How CM/UM bring Value

*Effective communication skills

*Clinical Expertise

*Advocacy

*Collaboration- "working in team "

*Knowledge of CoP

*Knowledge of Payor contract obligations

* Understanding Resources required

Cornerstone for a Plan of Care/Transition of Care

- Multidisciplinary team – It takes a village…..
- Everyone brings knowledge and skills – at the top of their license and within their scope of practice and ready to collaborate.
- Leading the team……. Case Management

How do Case Managers become the Leader of the Team ?

Leading the team

1

Build relationships:

Who are you and how to find you to enhance coordination

2

Integrate CM needs into MD and ancillary team workflows

- Pharmacy, therapy
- Interruptions: Minimize them
  - Care coordination rounds
  - Morning huddle
  - Service (e.g. hospitalist) contact

3

Monitor calls to physicians by type and frequency

- Target frequent types for PI
- Identify high maintenance physicians or ancillary groups

Why Transition of care team members Don't always Do What We Need

- The Influencers Within the System:
- Hospital leadership and culture
- Orientation and education- Doesn't include Transition of care or Case Management expectations
- Information support at the time of decision
- Continuity of the care team (MD, CM/SW, Therapy????)
- Coordination of the care team (CM, MD, other partners in care) workflow
- Often we work within a process that's reactive rather than proactive

Why we get "push back " ??

▶***They say:*** *"Too busy," "Not my job," "I don't know, you decide," "It's in my note."*

▶***Why they say it:***

- Excessive workload
- Input overload
- Frustration of redundancy
- Language barrier
- Too many "rule" changes
- Fear of being wrong

What's the Best Question?

- A: The one you don't have to ask. Structured properly;
  - Process → progressive decrease in UM calls to MDs
  - Physicians motivated to get it right the first time
  - Real-time prompts, support physician's accuracy of status determinations and completeness of the documentation

Asking the Question*

- Structure your questions for the situation:
- **Determine who's the decision maker**
- **Open-ended questions-** Avoid. Instead, use This vs. that
- **This vs. that not working?** Provide one choice
- **One choice not working?** Provide the answer
- **Allow for uncertainty**, but still get the answer

* *These comments assume a discussion between clinicians (e.g. RN) familiar with the patient. There is no intent to suggest inappropriate influence over the physicians clinical judgement*

Phone Etiquette

- Don't apologize. I'll assume the "Sorry to bother you doctor."
- Identify yourself, the patient and room number. Then you can start the question.
- SBAR. Have the chart, vitals, labs available.
- If you have a goal, opinion, and/or suggestion, then state it at the beginning.
- Repeat back a summary of the discussion and responsible parties for next steps if needed.

High and Low Maintenance Physicians

- **High**

Takes multiple contacts and calls

Charts are delinquent, notes illegible, brief, confusing….

Low response rate to queries

Declines requests for peer-to-peer with insurance

No one's surprised when the RAC pulls their charts

Seems to make the same CM mistakes over and over (and over)

- **Low**

Gets it right from the beginning

Call once, and it's taken care of quickly

Seems to grasp basic CM principles

Team player

You hope the joint commission picks their chart for the site visit

Improving “Difficult” Physicians

- Work on the system and process issues
- Use the tips on how to frame the question
- Track common problem areas to identify the ‘high maintenance’ physicians
- Use physician report cards
  - Provide comparative data, making it a competition
  - Validate the positive/negative impact of the MD

Improving "Difficult" Physicians

1. "Opt out" option
2. Mirror the statement – ***carefully***
3. Administrative consults - ***rarely***
4. Pt/family requests
5. Involve Physician advisor, peer-review (OPPE), or CMO
6. Report inappropriate behavior (not just overt or aggressive behavior)

Build a dashboard

Dashboard Components

- LOS (actual/expected)
- CMI
- Query rate and response rate
- Observation rates
- Rates of status changes
- Numbers of referrals to the PA
- Denials +/- win/loss rates
- # of positive/negative events (“difficult” physician)

Leading the Team using the CM Process

The Core Concepts

What We Need to Coordinate Care

- Knowledge of the needs, risks and issues experienced by individual patients, populations, organizations, and the community at large
- Clinical Knowledge of the Disease Trajectory
- Clinical Knowledge of emotional, psychosocial, and mental health needs
- Ability to manage towards outcomes (see the goals)
- A comprehensive understanding of the patient/family and their perspective and culture
- Attention to deviations and ability to take action
- Advocacy for patient/family resources

Why is Care Coordination Important?

- It is the glue that keeps the plan together and moving forward
- It's the marriage of information related to ADL's and IADL's
- Operationalizes comprehensive, holistic care concepts
- When there is a lack of care coordination, it's palpable…subtle at first and then overwhelming
- We miss subtle clues that the patient's condition is deteriorating/changing and don't have time to "course correct"

EVALUATION

Evaluates the client's status and goals

Determine and document the CM plan's effectiveness in reaching desired outcomes

Repeat at appropriate intervals

CM Notes: Should show action plan

Initiatives & Outcomes

- Bi Directional Communications
- Medication Assistance program
- Shared Charity Care
- High Risk Screening Tools (bi directional)
- Bed Side Handoffs
- Data Dashboard

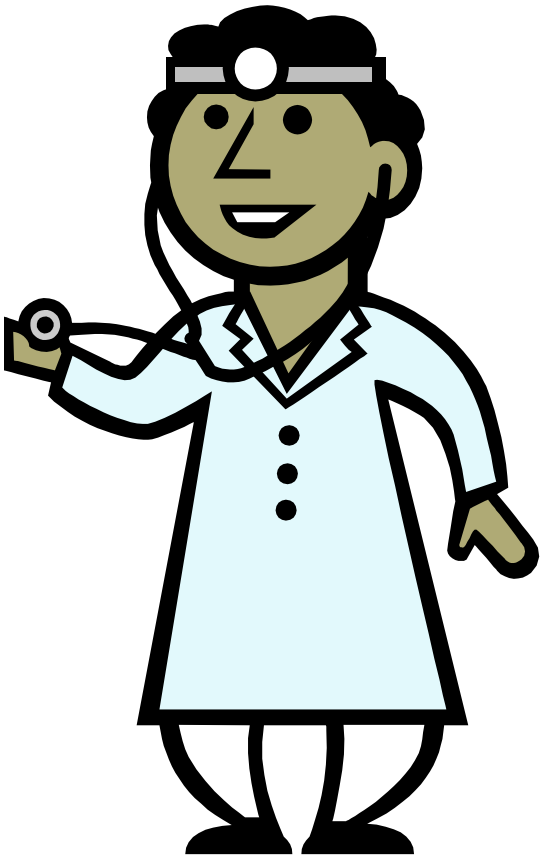
OUTCOMES

- Measuring the interventions to determine the outcomes of CM involvement
  - Financial
  - Avoid Charges or Potential Charges
  - Discount and/or Negotiated Arrangements (may be non-negotiables)
  - Reductions in Services
  - Reduced Emergency Visits

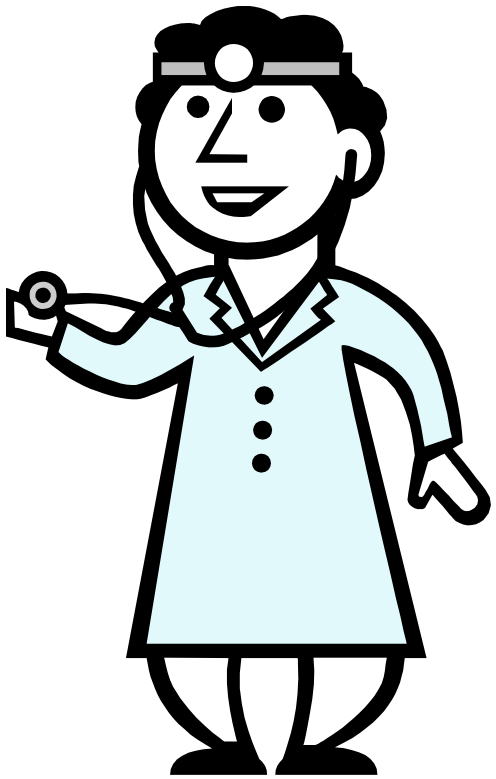
Building bridges

Doctors – Here is what they know

- Paperwork is not something I signed up for (includes understanding level of care)
- Patients in the hospital for long periods of time is bad, but it gives me lots of RVU's
- I always want the patient to like me
- The social worker will help me with touchy feely issues
- I take care of my patients one way, why should I change because the "level" is different
- The Case Manager will help me discharge the patient
- I got to see my sickest patients first
- I hate when someone asks me "what's the plan"



Doctors – What they don't know



- First, they don't know what they don't know
- How healthcare really works
- How to get patients from point A to point B
- How to ask for help
- That there are financial implications to the patient when we don't get it right
- Other's scope of practice

WHAT WE KNOW

- Physicians want to do the right thing
- Physicians truly care about their patient's and their patient's outcomes, but it's mostly medical, they don't think about economic outcomes for patients
- They have difficulty understanding that health care is a team sport
- They feel the burden of patient outcomes
- They don't often think of the plan for the way because they are busy thinking about the plan for the day
- Doing the right thing is not always easiest for the Docs

What We Need From Them

- To articulate the plan of care and goals towards discharge
- To discuss discharge with us early
- To stop by our interdisciplinary rounds
- To respond to level of care concerns
- To only admit patients when they meet criteria!

What is our duty?

- To be concise
- To be timely
- To be available
- To problem solve
- To be proactive
- To be informative
- To be credible

What does win-win look like?

- The patient is served
- The physician is supported
- The case manager/social worker has the disposition prepared and …… another one ready in the wings

The Patient Is Served

Clinically Comprehensive care and diagnosis

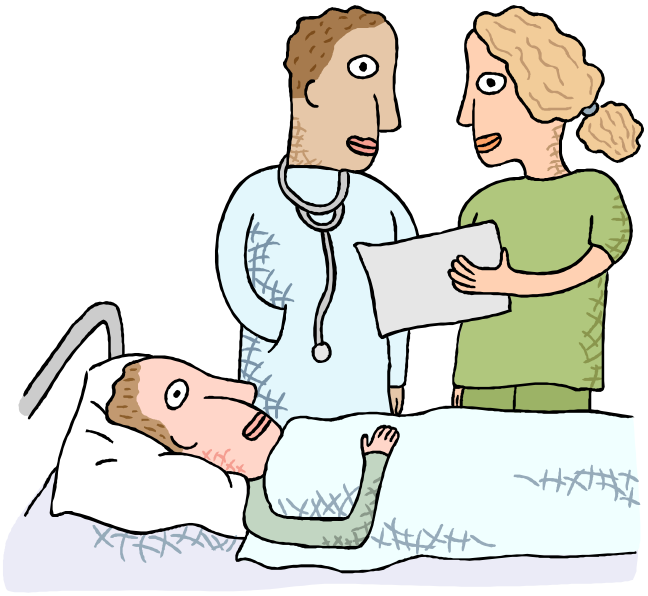
- Positive outcomes, medically stable
- Understanding of their health care needs and how to manage them in the community

Psychosocially

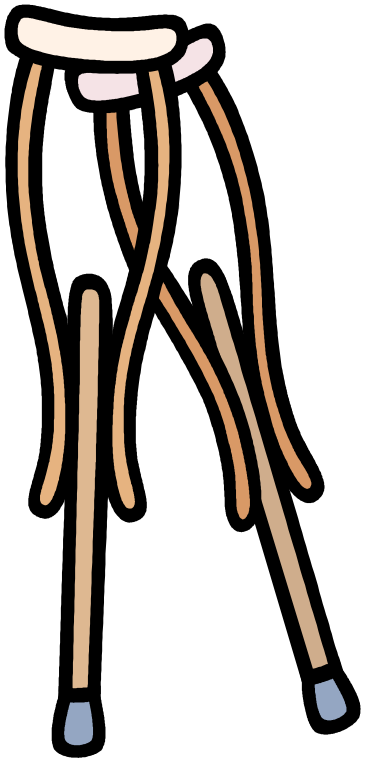
- The patient felt supported
- Patient's expectations were well managed
- Stress and coping issues were addressed
- Comfortable with the discharge plan

Economically

- Health care dollars/benefits used appropriately
- Out of pocket expenses held to minimum
- Least amount of productive work time missed



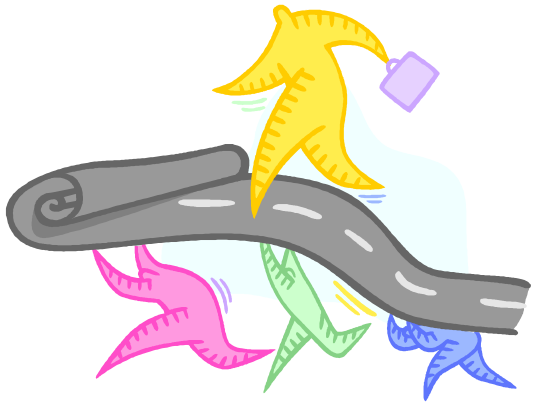
The Physician Is Supported



- The team has kept the drama at a minimum
- The patient's "needy" parts are supported by the team members
- Physician has time to see all of his/her patients
- The team is recommending the discharge plan and putting it into place (never ask, "what is the plan")

The CM/SW team are supported

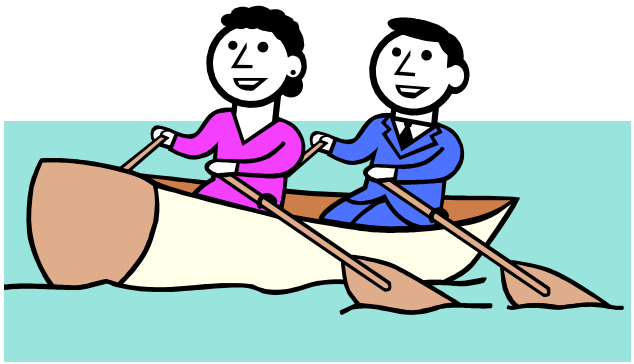
- Identification of discharge needs are determined early in the case
- Physician is signing and ordering the right things
- The patient/family are on board
- Plan One is a go, but there is one ready if not



Team Perspectives

Physician	RN Case Manager/SWker
• Early and Accurate Diagnosis • Tests, procedures, and consults on time • Positive clinical outcomes • Plan for the day • Discharge when I have time to get my paperwork is done	• Early and accurate diagnosis • Tests, procedures, and consults on time • Positive clinical outcomes • Plan for the Way • Timely discharge

Teams
The Common Denominators



System:

- Safe discharge plan, do no harm, utilize resources rationally

Patient:

- Have control, be among friends, not be harmed

Team:

- Decrease drama, arrange for discharge, do no harm

Building Collaborative Networks

- Nurture
- Support
- Build
- Key Relationships

Collaboration - Key Elements

- Accountability
- Respect
- Culture
- Skilled Communications
- Equal Partnerships
- Shared Outcomes

The action of working with someone to produce or create something
Wikipedia

"Collaboration is a dynamic, transforming process of creating a power-sharing partnership."
Toni J. Sullivan, USC

How Do Leaders Become "Collaborators" "Without losing influence"

- Commits to projects and group goals
- Demonstrates open mindedness
- Actions are reliable and responsible
- Meetings are prepared and structured
- Everyone gets a voice
- Creates a shared vision
- Has a spirit of cooperation and mutual support
- Shares and describes DATA!

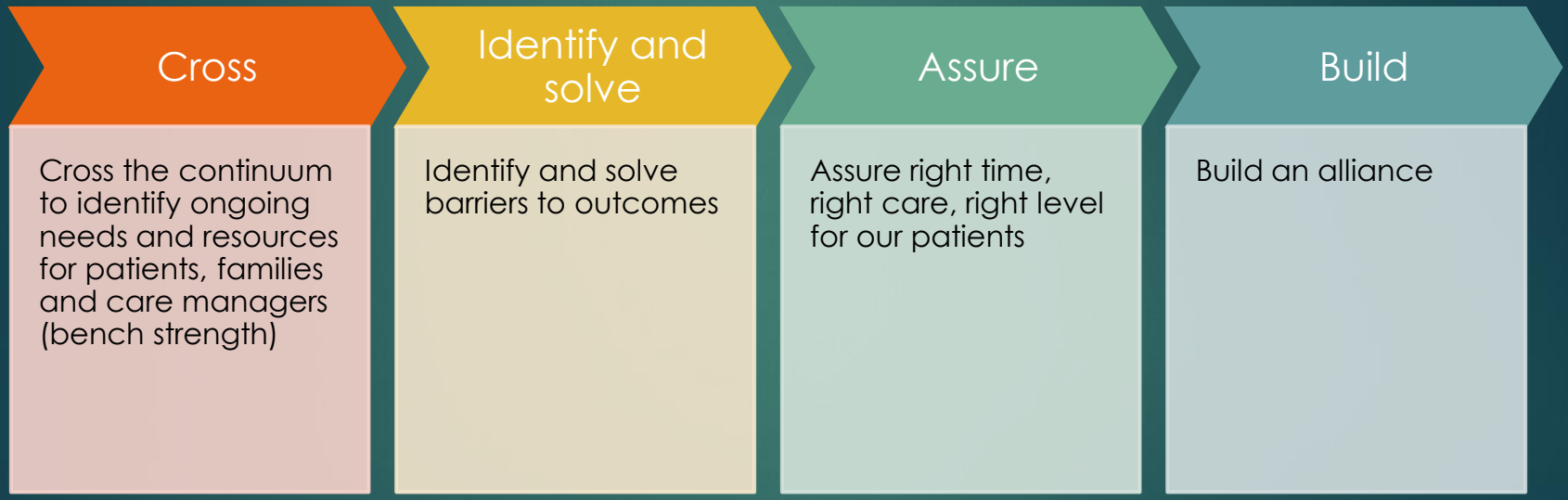
When these attributes are dynamic they are not seen as manipulative!

Great Collaborators engage people to produce extraordinary results

Top 10 Qualities of a Great Collaborator

Quality	Comments
EGOLESS	Check your ego at the door 3 Musketeers moto: "one for all, all one "
GENEROUS	Give without reservation of your knowledge, skills, help. Find a way to give the team what they need with a smile
CURIOUS	Ask the right questions at the right time Don't interrogate, let questions flow
APPRECIATIVE	Be sincere Don't be shy about expressing appreciation out loud
LISTEN TO UNDERSTAND	Listen patiently to what is being said Ask follow up questions for clarification
FLEXIBLE	Go with the flow Stay limber so you can "survive another day"
CONNECTS THE DOTS	Help people understand the connectivity Connect data to observations
GIVE & EXPECT TRUST	Make sure the team feels safe about sharing thoughts and ideas Create a no judgment zone
DISCIPLINED	Be "semi obsessed" with organization and time management Be key in delivery (not necessarily in charge)
Self-Motivating/Inspiring	Use your inner fire and passion Inspire others WITH your inner fire and passion

Leadership Creates A "Purpose"



Build Your Network!

- Use your personality
- Apply data
- Deliver a message
- Make MAGIC

So, who is within our network of influence and collaboration…….

- Consider the outcomes that the department must influence
- Beyond your team, who has a "stake" in the game
- How will your work make THEM look good?

Executives (C Suite)

- Independent thinkers
- Strategic
- Visionary
- Big Picture
- Willing to take risk when it makes sense

Key Points:
- Don't get into the weeds
- Be clear about the outcomes you are working to achieve
- Be innovative – weight the risks versus the outcomes

Finance/Revenue Cycle

- Thrives on details and accuracy (never give questionable data!)
- Takes everything seriously
- Calculated and precise in their actions
- Doesn't like "hype" … wants facts
- Not quick to make decisions
- Doesn't take things at face value
- Cautious about change
- They like to champion the underdog if the facts weigh in

Nurse and Nurse Executives

- Highly compassionate
- High energy
- Not data driven as much as "outcomes" driven (it's working better)
- High sense of commitment

Key Points:
- Respect Time
- Understand their important outcomes (quality)
- Educate

Physicians

- High Intelligence
- Compassion for the patient
- Competitive
- Independent
- Results driven

Key points:
- Be prepared – make sure data is correct and you can explain it
- Be brilliant, but brief
- Educate – Give lead time on decision making
- Draw a connection to the patient…..always

Post Acute Providers

- Collaborative
- Marketers
- Driven to grow
- Open to change, if it means growth

Key Points:
- Share honest, data rich feedback
- Keep them informed of changes
- Innovate with them

Our Objectives:

- Improve or maintain the patient population at optimal health in the community
- Shared responsibility of high risk, high complex patients (susceptible to readmissions)
- Maintain or improve the quality of care for the patients
- Decrease hospital ER visits and/or readmissions, manage access points.
- Increase patients understanding of transition of care plan and poly-interventions
- Manage cost and improve efficiencies
- Improve the communications between the inpatient and ambulatory settings
- Facilitate the coordination of patient care across the continuum to improve access & availability to services
- Improve the patient experience by engaging patients in efforts to attain self care goals and trust in the system by responding proactively to patient needs
- Improve provider satisfaction by increasing communication and decreasing duplication of services/tests


QUESTIONS