HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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## INSIDE



RELIAS MEDIA

# Team-Based Case Management Improves Care Coordination

*Streamline care, cut duplication*

*By Melinda Young*

A team-based approach to care coordination can work well as hospitals look for ways to streamline operations and improve quality.

One such program at The Valley Hospital in Ridgewood, NJ, has racked up positive outcomes, including:

- Reducing Medicare 30-day readmissions by 1.2%;
- Lowering sub-acute rehab utilization by 3.25%;
- Decreasing post-acute utilization by 3.6%;
- A 5% increase in the overall care transitions domain on patient experience surveys.

To streamline operations, the hospital re-evaluated the staffing approach, and looked for ways to improve the efficiency of each case manager and social worker, says **Margaret Pogorelec**, DNP, RN, CEN, NE-BC, director of care coordination at The Valley Hospital.

> THE VALLEY HOSPITAL FOUND THAT ALTHOUGH EACH CASE MANAGER'S CASELOAD WAS EVEN, THE ACUITY LEVELS WERE NOT.

For example, The Valley Hospital analyzed its unit-based approach to case management and found that although each case manager's caseload was even, the acuity levels were not. The hospital also used a standard approach to case management, with case managers on each unit handling both commercial utilization review (UR) and discharge planning. Social workers also handled discharge planning. One UR team focused solely



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on Medicare and did not handle discharge planning, she says. The new model separated the discharge planning and utilization review roles. *(See story on how to improve case management and care continuum efficiency, page 15.)*

"We have a case manager and social worker on each of the units. We also have transition coordination and the utilization review nurse," she explains. "There are one or two of them, depending on the unit. For every two teams, there is a complex care coordinator."

A major challenge in separating utilization review and discharge planning was finding staff to fit the new jobs. Employees could choose which one they wanted, and this did not result in a perfect fit — at least at first, Pogorelec says. "The discharge planning piece was a little easier, and the utilization review piece was more challenging," she adds.

With staff turnover and hiring focused on applicants with the specific skills needed, this worked out, she adds. The new model includes various levels of support, but it reduced duplication when compared with the old model.

"We had tons of duplication — between the case manager and the social worker, and between the utilization review, case management, and home care case management," Pogorelec says.

Previously, the case manager would prepare patients for discharge and handoff to home care coordination, although the work was already completed. The additional effort by home care staff was duplicative, she explains. "We put everyone into a figurative bag and tried to eliminate any duplicity so we could streamline the care," Pogorelec says.

Another change involved eliminating the role of fill-in case managers, who floated from one unit to another, going wherever they were needed. "We had a lot of these [floating] case managers built into the model, but there were complaints about the quality of their work," Pogorelec says. "It wasn't a good model for us because the whole idea of our program is that everyone has a specific job."

The new model includes built-in workflow flexibility because case managers on unit A can help case managers on unit B if that unit needs additional help. There are people, including Pogorelec, who fill in for people on vacation.

Another aspect involves the hospital's new population health department, which was launched in 2016 to support a defined population of a Medicare accountable care

## EXECUTIVE SUMMARY

A health system's focus on revamping its care coordination led to a reduction in some 30-day readmissions, as well as other benefits.

- The program, which focused on streamlining operations and improving quality, showed a 3.6% decrease in post-acute utilization.
- The health system started the change by re-evaluating its staffing approach and looking for ways to improve case manager efficiency.
- Discharge planning and utilization review roles were separated in the new model.

organization (ACO), says **Toni Modak**, BSN, ICM, PCC, director of population health at The Valley Hospital. The population health department also has payer contracts with private payers and manages tens of thousands of lives, she adds.

"We needed an infrastructure to support the ACO," Modak says. "We looked at the care delivery model where we're delivering care to our patients, and we put together a team of telephone case managers, who follow our patients across the continuum."

The goal was to follow patients' journeys and closing gaps in care. "We make sure they don't fall beneath the cracks, and really work closely with physician practices," Modak says. "We're there as a layer of support for physician practices."

In addition to the population health nurses, the organization created a role for population health staff navigators who are embedded in post-acute facilities. ■

# Tips to Improve Quality and Efficiency in Case Management Departments

*Start with shifting staff*

*By Melinda Young*

Hospital case management departments can improve efficiency and streamline their operations by following some tips from The Valley Hospital of Ridgewood, NJ.

Here are the steps the health system took to improve care coordination:

• **Reassign staff.** "We took home care coordinators into our department," says **Margaret Pogorelec**, DNP, RN, CEN, NE-BC, director of care coordination at The Valley Hospital.

They asked case managers whether they preferred discharge planning or utilization review (UR) work, and assigned them to a role. The nurses already performing Medicare UR were trained on UR for commercial payers as well. One nurse and a social worker were assigned to identify patients at risk for a 30-day readmission, and the hospital created a full-time ED case manager position, she says.

A new role is the complex care coordinator, who has a master's in social work. The coordinators handle high users of hospital and ED services. Their patient load is smaller than those of other case managers — maybe six to nine patients at a time. But their patients might be homeless and suffering multiple chronic conditions, as well as health access issues, Pogorelec explains.

Another new role is the transition care coordinator. These case managers cover two units, 15-20 patients at a time. They provide an additional level of support, including scheduling follow-up visits, and sending patients to the next level of care.

"All of these changes were budget-neutral because we streamlined so much of the workflow, not adding staff — just reorganizing them," Pogorelec says.

It takes time for the reorganization to work, she notes. When The Valley Hospital first reassigned case management staff according to their preference of either UR or discharge planning, there were too few UR associates.

"We had more people interested in discharge planning than utilization review," Pogorelec says. "But as people retire, through attrition, we reposted those positions as utilization review and hired from the outside."

## EXECUTIVE SUMMARY

One of the first steps to streamline case management operations is to reassign staff to new roles, such as focused discharge planning jobs and utilization review.

- Another method is to create a risk assessment tool to assess each patient, and indicate when patients need a referral to a complex care coordinator.
- Daily huddles help team members, providing time to discuss potential problems, and to discuss how to shift work within the team to be most effective and efficient for the day's caseload.
- Focusing on social determinants of health allows case managers to help patients with sociobehavioral health issues, as well as other factors underlying patients' poor health habits.

Pogorelec did not want to force people into a role they did not want, so using attrition to help with realigning staff was a better long-term option. It took about six months. The only exception involved a case manager who desired to move into a leadership role. There were no leadership options in discharge planning, so the case manager became a UR leader, Pogorelec says.

**• Identify at-risk patients.** "We created an algorithm, our modification of a tool by the American Academy of Family Physicians," she says. "We use it for clinical complexity, and added additional layers for social determinants of health."

The Valley Risk Assessment Tool assigns each patient a level of complexity from one to nine. *(See samples from tool in sidebar on the right.)* Those scoring at a high complexity level are referred to the complex care coordinator, she adds.

There also is an automatic referral to the case management team when a patient has visited the ED five times or more within six months, she says. For example, the ED social worker can step in if a person has ended up in the ED because he or she could not fill prescriptions in the community. The social worker can ensure the prescriptions are filled before the person leaves the ED, she explains.

**• Hold daily huddles.** The team huddles daily to discuss any potential problems, and how to shift work within the team to be most effective and efficient for the day's caseload.

"We let everyone know what it looks like in the emergency room. If there is a high census, we talk about how to prioritize case management," Pogorelec says. "The daily huddle allows for transparency amongst the team, so everyone can prepare for what the day looks like."

**• Focus on social determinants of health.** The case management team can focus on the patient issues that usually are overlooked in clinical healthcare settings: social determinants of health.

For instance, many organizations focus on episodes of care, and develop a discharge planning solution that meets the need of that episode, Pogorelec says. This limits the ability to prevent subsequent admissions based on mental health disorders, finances, access to resources, and family support, she says.

"In our model, the complex care coordinator, working with our team members across the continuum, is able to plan for circumstances that exist outside the four walls," she explains. "For example, if identified in the hospital

## Risk Assessment Tool Helps Identify People in Need of Case Management

The Valley Risk Assessment Tool, created by The Valley Hospital of Ridgewood, NJ, is a two-page, two-column chart that assigns a level to each category of risk.

Here are criteria for patients to qualify for level four:

- One or more chronic diseases with significant risk factors;
- Not at treatment goals;
- Problems with one to three chronic diseases;
- Five or fewer medications from two or fewer prescribing physicians;
- Normal function;
- More or frequent office visits.

A level one simply states that no primary prevention or further intervention is necessary because the "Patient is healthy, with no chronic disease, or significant risk factors; no problems, medications, functional, and utilizations."

By contrast, a level eight includes:

- Long-term complex: no finances, inadequate social supports;
- Difficult families that need guidance with accessing services and decision-making;
- Housing issues;
- Patients readmitted due to lack of social or financial supports that are complicated;
- Complex, insurance/disability/SSI problems;
- Medication access and affordability issues;
- Cases involving Elder Care Legal Service issues;
- Medicare and Medicaid issues;
- Complex observation patient with discharge needs;
- Multiple resource needs;
- Partial hospitalization programs;
- Outpatient agencies, day programs, psych discharge to community, refusals. ■

admission that there may be an unsafe home environment, not only do we mitigate those circumstances as much as we can during the hospitalization, but we work with our team members in home care, population health, and the post-acute setting, in an effort to ensure and follow up on our discharge plan."

• **Collaborate and provide follow-up care.** The case management team formed a relationship with the hospital's population health department, which helps with handoffs. The team also works with home care organizations, nursing facilities, and other providers. "You have to have people in the community to follow the plans you set forth," Pogorelec says. "There is only so much you can do telephonically, from the hospital side."

While the hospital does not own skilled nursing facilities (SNFs), the hospital's population health staff — RNs and physical therapists — work in the SNFs and coordinate warm handoffs. These are post-acute navigators, a role launched in 2016, she explains.

"Patients go in a lot of different directions when they leave, so it's critical that we have someone touch base with them," Pogorelec adds. ■

# Healthcare Facility Uses Lean Principles to Enact Systemwide Culture Change

*By Melinda Young*

The Cleveland Clinic started process improvement with a classic problem-solving approach of understanding its gaps in quality service.

The choice was between closing the quality improvement gap through continuous improvement, led by a small team of professionals (which was the traditional approach), vs. establishing a culture of continuous improvement that involves everyone. The Cleveland Clinic chose the more challenging approach, which eventually will involve all employees.

"We had been using a fairly traditional process improvement approach for about six years," says **Lisa Yerian**, MD, director of enterprise continuous improvement. "Then, we realized that although we could accomplish specific projects and deliver results, we had not fundamentally changed the culture. We were around 40,000 caregivers, and had a small process improvement [PI] team."

If the health system — which has since grown to more than 60,000 employees — relied solely on the PI team, the results were limited.

"We were unable to think in a large way about the care we delivered, and how to improve on that," Yerian says. "We embarked on a culture of improvement."

The driving force of this systemwide cultural change was the belief that the organization could not improve fast enough, or in a sustained way, if caregivers were not engaged in solving problems and delivering better care to their patients, she adds.


## EXECUTIVE SUMMARY

A hospital's process improvement (PI) could begin with a focus on reducing gaps in quality service. The Cleveland Clinic started such a process, focusing on engaging all employees in process improvement — rather than leaving the work to one PI team.

• When using a traditional approach to process improvement, the health system could improve some processes, but had not changed the culture across the system.

• A systemwide cultural change was needed. The health system drove this change, following a belief that the organization could not improve fast enough or in a sustained way without engaging all caregivers in the problem-solving process.

• There were three possibilities why the systemwide culture of process improvement did not already exist: a desire gap, a capacity and team gap, or a capability gap. The Cleveland Clinic worked to reduce the capability gap.


## Changing the Capability Gap

The first step to creating this systemwide cultural change was to understand why the PI culture did not exist. They found three main possibilities:

• **A desire gap.** One possibility is that a health system's staff does not want to change.

"We dismissed this reason because we could tell in the culture we experience here that people very much care about the patient," Yerian says. "Our mantra is 'patient first,' and people are very centered on patients."

For example, when leaders walk through the halls and talk with employees, they can see that people are working hard to improve service and processes, she adds.

"A component of our culture is to feel that you are responsible for a patient's care, and you want it to go well," Yerian says.

• **Capacity and team gap.** This issue involves a hospital not having the time to address process improvement.

"People are very busy, see a lot of patients, and they don't have the time to spend on improvement," Yerian says. "That is a real factor, but it's just not a factor we could countermeasure."

A time and capacity gap cannot be resolved easily. Plus, just giving people more time might not solve the problem, she adds.

"If we gave people more time, I wasn't confident that it would result in measurable improvements," Yerian says. "As we were working through this, we got lots of information from other stakeholders across the organization. We were partnering with executives, managers, and bedside care managers from multiple teams to find out what occurs, how they felt about it, and what they thought."

• **Capability gap.** "This is the gap we spent our efforts working on," Yerian says.

The theory is that the health system could make process improvements if employers were oriented toward patients first. If they wanted to improve, they were given the capability to improve.

The system would need to teach staff how to identify problems in their work, and perform complex problem-solving. The key is to engage employees in the improvement process, as part of their day-to-day workflow. This solution has far greater potential impact than the traditional PI committee approach, she notes.

"If you think about more than 40,000 employees and now 66,000 caregivers, and they each have the ability to improve quality across all domains, vs. the prior state of 30 people on the continuous improvement team, this can have a dramatic impact for our patients," Yerian explains.

Once the Cleveland Clinic settled on addressing the capability gap, the question was to figure out how to engage staff.

"When we started out, we found through conversations an understanding that we couldn't grow our capability across 40,000 people all at once," Yerian says. "We started with one team, learned from this experience, and then went to the next team, using what we had learned."

The first team was in the finance division. Yerian trained the team, along with a couple of people from the existing quality improvement (QI) team.

"They talked about the problems they faced in their work," she says. "We realized the first capability to build was around problem-solving. We used a common, complex problem-solving methodology."

The methodology, called A3, involves Lean processes. "This was used by Toyota to represent the methodology to work through problems in a systematic way," Yerian says. "You define a problem, understand the current problem, do an analysis around the cause, and test various solutions — plan, do, check, and adjust."

It is a commonly used QI tool, where people use cycles of experience and learn to use data to drive improvement, she adds.

One way to teach A3 is through directing teams to use it to solve their own problems: "They were learning by doing, which is different from learning by listening or reading," Yerian says. "What happens when people learn by doing is they build the skills to do it again, and they own the results. Our team started to solve these problems, and could see they were solving their problems and improving. They were very excited about it because they had never done anything like this before."

Once the team showed progress, they invited other leaders to observe. This helped spread enthusiasm for the improvement process.

"My impression was that what engaged the other leaders was more the excitement of the team around what they were capable of doing," Yerian says. "There was a process they did in their team that took three hours, and they got it down to under 30 minutes. They used the same solution to apply to other processes." But it was the team's excitement that helped with buy-in, she adds.

Over time, the team approach spread to include more than 300 teams and 18,000 caregivers/staff members, she says.

The Cleveland Clinic placed videos on YouTube, showing teams' process improvement success stories, including reducing patient wait time. *(The videos can be viewed at: http://bit.ly/34Y6PZp.)*

"It's very organic," Yerian says. "We've been pleasantly impressed by the level of improvement." ■

# Optimizing COPD Discharge Planning

*By Jeanie Davis*

Patients are not one size fits all when discharged with COPD. "They're complicated, not one defined entity," says **Carolyn M. D'Ambrosio**, MD, MSc, director of Pulmonary and Critical Care fellowship at Brigham and Women's Hospital, and associate professor of medicine at Harvard Medical School.

"These are patients who typically get their disease from smoking tobacco, which increases risk for many other medical conditions, specifically coronary artery disease," she explains.

Smoking affects every COPD patient differently, D'Ambrosio says. "Some patients have significant destruction of lung tissue characterized as emphysema with COPD. Other patients have minor airway obstruction with only minor destruction of lung tissue, so it's hard to put them in the same category."

However, "in readmission rates they're all lumped together," she adds. "That's the biggest problem with proper discharge planning for COPD: It's not one size fits all."

Her team's assessment is comprehensive. "Breathing: Is it back close to baseline, when it was good as can be? Oxygen levels: Does the patient need oxygen all the time, when they're sleeping, when they exert themselves? We make sure if they do need oxygen, they can go home with it on, and tanks delivered to their home."

It also is critical to ensure patients use correct medications, inhalers, or nebulizers. Do they know the proper inhaler technique? Are they taking the correct medication for their COPD? Do they understand their inhalers?

One of biggest problems, D'Ambrosio says, is patients forget which is their everyday inhaler, and which is their rescue inhaler. "It can be very complicated for them," she explains. "Very often, we label the inhaler. We go over using it, and ask the patient to repeat it back, to make sure they understand it."

> "THAT'S THE BIGGEST PROBLEM WITH PROPER DISCHARGE PLANNING FOR COPD: IT'S NOT ONE SIZE FITS ALL."

Patients mostly are older people, although some are in their 30s and 40s. "Those in the older age range might be living alone without someone helping them, which is a bit of a challenge," she explains. "When they're short of breath, and the inhaler is across the room, that's an effort to get it."

Best-case scenario is when the discharge planner, nurse, and pulmonologist can help the patient strategize, she advises. "We can figure out where the best place for their inhaler is — in their pocket, or on the bedside table. Simple things like that, so they're not struggling to find their inhaler."

Patients must receive pneumonia and flu vaccines. "Also, make sure everything else is tuned up," she adds. "If they have other conditions, like heart disease and heart failure, make sure they're treated before leaving the hospital. You want their condition to be optimal, or they will be coming back."

Home assessments are valuable. If necessary, some patients experiencing more difficulty can be sent to a rehabilitation hospital short-term. Short-term visiting nurses also can be arranged to ensure inhalers are labeled, and everything is set.

Some patients benefit from outpatient rehabilitation two to three times a week for up to four weeks, until they are stabilized.

Unfortunately, not all outcome are positive. "Sadly, the data don't support these improvements helping readmission rates, largely because patients are not one-size-fits-all," D'Ambrosio says. "We know that improving heart failure has reduced readmission rates. However, for patients with COPD, something as simple as the common cold can get them readmitted because their COPD is severe."

Her team has identified specific interventions that can lead to short-term improvements. But the patient may be unable, or unwilling, to make necessary changes. "As disease progresses, some are still smoking and still injuring their lungs. We offer smoke cessation programs, but nicotine is tough to kick. Many people who smoke live with people who smoke, so they're being exposed to secondhand smoke."

Stabilizing the patient before they leave is the best approach, D'Ambrosio says. "We make sure they have the services they need, like oxygen, outpatient, or inpatient rehabilitation. If all has been planned carefully and arranged appropriately,

then we've provided the best care we can. They're on the best medicine, and they're stabilized."

There must be close follow-up with the pulmonary doctor, she adds. "They need to be seen in the office after two to three weeks to make sure they're settled on a good path."

## Lean Analysis Reduces Readmissions

The "Five Whys" of the Lean healthcare model are key to reducing readmissions, says **Lesli McGee**, MSIHC, corporate vice president of care coordination and operational improvement at McLeod Health in Florence, SC.

Lean is a healthcare management system that seeks to continuously improve and eliminate waste in patient care. McLeod Health uses the tools and techniques of Lean improvement methodology to constantly re-evaluate their processes, and find ways to make outcomes more successful, McGee explains. "This equates to constantly improving value for the patient."

To apply the Five Whys to the COPD population, which readmits at a high rate, McLeod Health implemented a readmission assessment that incorporates finding the root cause of each patient's barriers to health. In assessing a readmitted patient, the case manager asks "why" to each answer, digging deeper.

"We keep asking questions until we get to the true root cause, which may be very different than their first answer," explains McGee. "Unless we get to that root cause and put a plan in place to correct it, that patient is going to return to the hospital."

The questions run like a decision tree. Follow-up questions asking a deeper "why" are based on the answers. "In the instance of medication noncompliance, they ask if the patient took their medications. If the patient answers 'No,' rather than label them as noncompliant and stopping there, they use the Five Whys," McGee explains. "They may discover that the reason the patient didn't take the medication was that they didn't have their prescriptions filled. They ask 'why' again. It may be that the patient can't afford the medication, or they didn't have a ride to the pharmacy. Both issues are easily corrected by a resourceful case manager, but they have to know about the problem."

If the answer to the first question is that the patient filled the medications, then the decision tree takes the case manager down another path, learning the patient's health literacy level, understanding assistance the patient receives at home, and even where the medications are kept at home.

"There are so many variables with each patient, that knowing what to fix is a huge key to reducing readmissions. Patients don't willfully and intentionally decide to quit taking medications; it's rarely ever that," McGee says.

She adds: "In questioning the patient and family, it's important to be gentle, helpful — not blaming the patient. You've got to keep digging, which may feel invasive at times. We're not finding fault; we're finding solutions to the problem. That must be the tone."

It is important to ask questions regarding caregiving, diet, and other factors involved in the patient's home care. Transportation to doctor appointments often is a barrier.

"Case managers might schedule all the needed follow-up appointments, but if the patient can't get a ride on two different days, they won't go to two different appointments," says McGee. "We have to think about the patient's needs, and work to meet their needs by scheduling both appointments on the same day."

## Time for Palliative Care?

McGee finds that some patients who have used all medical interventions and are readmitted often are candidates for palliative care. "If the patient has a history of not engaging in their treatment, or has exhausted all their options, it may be time for a palliative care consult, so we can help them find the best quality of life for the remainder of their life," she explains.

Case managers often run into resistance when suggesting this move, McGee admits. "We find that physicians are not familiar with palliative care, and families struggle with making that decision. We do what we can without destroying trust, and try to support them in their decision-making." ■

# Career Outlook for Case Managers

*By Jeanie Davis*

In today's hospitals, the role of case manager has expanded greatly as regulatory demands have increased. Case managers play a pivotal role in their hospital's bottom line, ensuring the hospital receives reimbursement (and avoids penalties) from insurers and the Centers for Medicare & Medicaid Services (CMS).

Case managers in large hospitals have moved into C-suite roles, where they can greatly influence the hospital's processes and procedures to improve the patient's experience and outcome. They also can address payer and regulatory issues.

It is a much broader role for case management, which always has attracted people with an innate nature to help others, says **Vivian Campagna**, MSN, RN-BC, CCM, the chief industry relations officer for The Commission for Case Manager Certification.

"Nurses, social workers, therapists, pharmacists, and physicians come to this profession because they want to do the right thing," she explains. "They want to help people get the best healthcare possible."

## Affecting the Bottom Line

In today's hospitals, case managers are responsible for ensuring evidence-based patient care is delivered appropriately, with a good outcome. Case managers must be "lifelong learners," always aware of the latest treatments, therapies, and applicable regulations, says Campagna.

The case manager is at the bedside, explaining treatment options to patients and families so they can navigate the confusing maze of healthcare, she adds. "They're given so much information, so many options, so much to consider, it gets overwhelming," she explains. "The case manager is the person helping them sort it all out."

> "THE CASE MANAGER MUST DETERMINE THE BEST OPTIONS TO HANDLE THE SITUATION, ADVOCATING FOR THE PATIENT EVEN WHEN IT'S DIFFICULT."

A strong ethical sense is key to a case manager's professionalism, Campagna adds. "One of our most important principles is that the patient comes first. We act in the best interest of the patient at all times, even when this can involve a conflict within the hospital. The case manager must determine the best options to handle the situation, advocating for the patient even when it's difficult."

In this situation, case managers identify evidence-based data to support the better option, she explains. "With those data, they may be able to sway a decision."

Case managers must understand value-based care, Campagna adds. The case manager is a team leader who will go to the physician or the team to identify priorities in a patient's treatment plan, and accelerate the pace. "The case manager understands the need to move along in a timely manner," she explains.

Preventive care programs are part of the Affordable Care Act, designed for at-risk populations who have costly chronic conditions such as asthma, COPD, diabetes, depression, and heart failure. Case managers can make a significant impact by motivating patients to improve their health, which will reduce hospitalizations.

"Ability to think creatively" is a key trait in a case manager, adds Campagna. "We work with insurance benefits, and sometimes benefits aren't sufficient. The creative case manager will find alternative ways to do it — community resources, friends, neighbors who can provide services without cost. The creative case manager will organize that."

## Ready for the C-Suite?

Many case managers enjoy the day-to-day interactions with patients and families, and want to stay in that realm. Others are drawn to the C-suite, where they

can influence strategic planning and administration, says **Holly Worsham**, DNP, MSN, RN, a consultant and vice-president at Kaufman-Hall.

Executive-level case management positions are available at many large hospitals and healthcare systems. "They are looking for business skills and higher education in those case managers, either an MBA or MSN," says Worsham. "A lot of nurses have been leaning toward MBA so they have well-rounded business acumen."

At the C-suite level, case managers can help develop strategies that meet regulatory and hospital goals. "Having a case manager in the executive level helps guide the C-suite and sets the processes in place to meet CMS expectations, and help the hospital's bottom line," says Campagna.

"In many ways, CMS is trying to get hospitals to operate on a 24/7 basis, instead of a weekday schedule," she adds. "Value-based care is about providing services when needed. Case managers are good at taking data and sharing it with administration to support changes in hospital structure and processes. They can make a real contribution in that regard."

## Enhancing Professional Growth

Certification is part of professionalism, Campagna says, as it shows competency and proficiency. "Employers respect certification, as it shows demonstrated expertise. Mentoring is also essential to help professionals from a broader range of disciplines who are entering the profession to understand the nuances of care coordination and how to do it best," says Campagna.

Worsham is an advocate for virtual mentoring via LinkedIn and professional organizations. "People who have been at one hospital for a long time can benefit from outside influences if they want to expand their knowledge base and grow professionally."

She adds: "Mentoring helps both the mentor and the mentee strengthen and challenge the status quo. Often, people who work at bedside aren't aware there are so many other career paths open to them." She encourages case managers to join their professional organizations, or reach out to colleagues on LinkedIn. "People are very open, very friendly; they want to help," she says.

Virtual positions are giving case managers greater options for career advancement, Worsham adds. "In some cases, you will have to relocate for a leadership position. But there are more and more positions that allow case managers to work remotely."

The major payers provide virtual case management, she explains. "Home health agency corporations are providing remote and community-based case management. Some companies provide virtual nurses who handle nonclinical activities, such as quality and case management functions."

Consulting is another option, which exposes case managers to multiple facilities and health systems across the country, Worsham adds. "That's the beauty of being a nurse — there are a million different options, many of which you maybe didn't even know existed." ■

# Tips for Becoming a More Effective Leader

*By Jeanie Davis*

You worked hard to reach your goals in nursing. As a case manager, you have a sense of leadership. But are you facing lots frustration in your position? Has your personal health deteriorated? Have you thought about quitting? Have you noticed that other team leaders seem stressed as well?

If this sounds familiar, it is time to listen to **Anton Gunn**, MSW, CDM, CSP, an inspirational speaker who has empowered thousands of healthcare leaders. He teaches simple skills that help nurses and case managers become more effective leaders.

## Gain Trust, Understand Frustrations

First, you must understand the roots of your own frustrations — because your team members share those same problems, Gunn says. "Your responsibility is to help your team solve the challenges that cause frustration. That's the bottom line."

Every person asks three questions every day, although they will never verbalize these questions:

- Do you care about me?
- Will you help me?
- Can I trust you?

"Every person working under pressure and stress is asking these questions," says Gunn. "Do you care what I'm having to deal with every

single day — the number of patients, the challenges? Will you help deal with a difficult physician?"

As a leader, the answer has to be unequivocally "yes" in words and actions, Gunn says. "How are you doing to show your team you care about them and their concerns? How will you demonstrate as a leader you're helping your team to overcome those challenges? You can't just talk about it; you must show how you're removing the obstacles. You must take action."

Can they trust you? Will you have their backs when things get difficult — or are you unreliable? "People who don't help, don't care, make the work environment unsustainable," he says. "That's why people will leave."

It is important for the case manager to build that system of trust. "Let each team member know they matter and they are valued, whether it's the social worker, utilization review, physician, physical therapy," says Gunn.

The focus is on the patient, but do not forget the patient's family. "You've got to consider how the patient and family perceive your efforts," says Gunn. "Think about how you communicate verbally and through your actions. Are you putting them at ease? Are you letting them know they can trust you?"

## Raising CAIN

As a leader on the patient care team, case managers can raise the bar in patient care, says Gunn. He uses an acronym that outlines the four keys to elevate effectiveness, called Raising CAIN:

• **Communication.** Let people know your "why" — why you became a nurse, why you became a case manager. What motivates you in your profession? This has nothing to do with paycheck or job description. When others know your driving force, they understand where you are coming from. When you take time to understand a team member's "why," you can more easily motivate them. Your job as a case manager becomes easier when you dig beneath the surface to understand your team members.

Also, pay attention to your words, tone, and body language. These are critical points in interpersonal communication that are getting lost in today's digital world, says Gunn.

"Nursing involves face-to-face communication, so you've got to tap into interpersonal skills," he explains. "Be sure your body language is trust-building, not confrontational."

• **Attitude.** "Your mindset is more important than your skill set," says Gunn. "It doesn't matter how impeccable your clinical skills are. If you don't have the right mindset about your work environment, the job you do, and the mission you're supporting, your skill set won't matter. You won't be as focused or successful, because you don't have the right mindset."

Many marginally talented people overperform, and many greatly talented people underperform, he points out. "It's about their attitude, about what they do every day."

A leader must show an attitude of success, and gratitude for the opportunity, for making a difference in people's lives, Gunn explains. "You have to cherish the role you play in helping people live a longer, healthier life."

• **Influence.** The more your leadership skills grow, the more you can influence others, says Gunn. "When you consider yourself to be a 'servant leader,' you are meeting the needs of others," he explains. "That's when you add value to your colleagues, your team, and your patient. You become a more influential person."

At this point, you are at the top of your profession — the tipping point — where you will observe more than others. You also will become more influential to hospital leaders. You may find the CEO leaning on you as a leader. At that point, you can greatly increase your level of influence. You can help make the changes you have recognized as necessary. You can make changes that brought you to that calling — to improve the healthcare system.

• **Network.** Take every opportunity to grow as a leader, and gain more influence. Attend professional conferences where you can grow a powerful network, Gunn advises. "You'll learn so much from your colleagues. You'll benefit from opportunities you never thought possible. Stay connected with these people; build a massive network you can lean on and learn from. They can help you with your challenges."

Remember this axiom: "The greater your network, the greater your net worth," he adds. ■

## COMING IN FUTURE MONTHS

- Improve utilization review management
- Study highlights need to focus on whole person in case management
- Study notes trend about hospital readmissions
- Hospital's readmission outcomes improve dramatically

HOSPITAL
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# CE QUESTIONS

1. **According to an operational improvement project implemented by The Valley Hospital, which of the following strategies could improve efficiency and streamline operations?**

   a. Ask the same staff members to perform care coordination, utilization review, and discharge planning.
   b. Refer issues related to social determinants of health to the population health department.
   c. Assign employees to roles that reduce overall staffing redundancy, and create a risk assessment tool.
   d. Hold daily text message huddles, eliminating time wasted by in-person meetings.

2. **Which is a key trait in case managers, according to Vivian Campagna, MSN, RN-BC, CCM?**

   a. The ability to reduce costs for hospitals.
   b. Organizing and staying on top of paperwork.
   c. The ability to effectively navigate office politics.
   d. The ability to think creatively.

3. **What is the purpose of the Five Whys in reducing readmissions for patients with COPD?**

   a. To determine why a treatment is unsuccessful.
   b. To find the root cause of an issue, such as why a patient is not taking medications.
   c. Physicians use the Five Whys to explain COPD treatment to patients.
   d. Patients use the Five Whys to question their course of treatment.

4. **What are three of the main gaps that need to be addressed when changing to a culture of process improvement?**

   a. Desire gap, capacity and team gap, and capability gap
   b. Staffing gap, leadership gap, and resource gap
   c. Workflow gap, teamwork gap, and quality improvement gap
   d. Experience gap, job passion gap, and skills gap