Introducing HCM v3.0
A Standard Model for Hospital Case Management Practice

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ABSTRACT
Purpose/Objectives: Like the professional definitions of case management, the practice of hospital management is a dynamic process. However, because hospital case management programs come in so many shapes and sizes, there is a widespread tendency to forego the process and instead focus on the static tasks associated with utilization review and discharge plan arrangements. As a result, the research identifying best practices is inhibited and hospital case management practice is constrained. This article speaks to the need for a standard approach to hospital case management and offers a model that positions the hospital case manager as the primary patient advocate and physician partner that are among the essential ingredients for successful participation in accountable care organizations, progression-of-care management, and transitions of care support.

Primary Practice Setting: Acute care hospitals, integrated delivery systems.

Implications for case management practice:
1. Hospital case managers must practice in accordance with the professional process of case management.
2. Hospital case management programs must be structured in such a way as to support the professional process of case management.
3. The roles and responsibilities of hospital case managers must be unmistakably defined to make certain that proactive advocacy is visible as the essential ethical obligation.

Key words: accountable care organization, case management practice, hospital case management model, patient navigator, patient throughput

HISTORICAL BACKGROUND OF CASE MANAGEMENT IN THE HOSPITAL SETTING
In the early 1980s and in preparation for the prospective payment system, Karen Zander and her team at New England Medical Center (NEMC) revolutionized the primary nursing practice model and developed what became known as a clinical nurse case management model. Zander’s model empowered nurse case managers with the authority to manage an assigned group of patients through a hospital course. This led to a reduction in fragmentation of care and to better control of resource utilization (Zander, 1990). Under this model, the primary nurse initially assigned to the patient followed the patient as she or he moved throughout the continuum of care complementing the role of the primary nurse at each location. The nurse case manager ensured seamless transition, provided updates to the new clinical team on diagnostics and outcomes, and offered comfort and security to the patient and family to counter the natural apprehension accompanying each move or change of clinician.

Around the same time and motivated by the same issues as NEMC, Carondolet-St Mary’s in Tucson, AZ, developed a case management program that positioned selected nurses as responsible for managing the process of patient care along a continuum that extended from inpatient to community health centers. With the rapid introduction of managed care in Southern Arizona, case management pioneer Phyllis Ethridge piloted the growth of the model into a nursing health maintenance organization (HMO) that contracted with managed care companies to identify, stratify, and closely manage high-risk patient populations through the entire continuum in order to reduce resource consumption.
length of stay, and readmissions and improve the health status of plan members (Rossi, 2003).

Simultaneously, in 1982, the Robert Wood Johnson Foundation demonstration projects in 24 hospitals around the country to test its Hospital Initiatives in Long Term Care (HILTC) program. The participating hospitals agreed to develop programs to meet the clinical challenges of the chronically ill Medicare population that would be affected by the anticipated shorter lengths of stay under the prospective payment system. The HILTC hospitals created case management programs, each markedly different from each other. With the exception of five hospitals, which created medical management models that bridged the transition of patients from hospital to home and worked cooperatively with long-term care coordination programs and/or community health clinics, each of the other HILTC hospitals created community care coordination programs (Capitman, Macadam, & Yee, 1988).

Case management had long been firmly rooted as a method of securing, coordinating, and advocating for health and human services in communities, whether the case manager is a nurse, a mental health or social worker, a counselor, or the neighborhood clergy. But these innovative programs marked the introduction of case management concepts into the acute care environment. In the taxonomy of models, and borrowing technological version labels, I identify this as the first version of hospital case management: HCM v1.0.

Subsequently, as hospitals buckled under the new prospective payment system and the economic pressures from the expansion of managed care under the HMO Act in 1990, hospital projects to downsize and reduce costs proliferated. These projects, led by consultants who were spurred on by articles describing the NEMC experience, targeted the departments of utilization review (UR) and social work (SW) as ripe for expense reduction and key to reducing length of stay. The UR department typically consisted of registered nurses conducting a chart review for the purpose of meeting regulatory and commercial payer medical necessity requirements, whereas the SW department consisted of both master’s- and baccalaureate-prepared social workers who were generally consulted by the nursing staff to facilitate home health arrangements or patient placement in nursing homes. Back then, discharge planning (DCP) was still the responsibility of the primary nurse.

Rather than building on Zander’s clinical practice model where patients were followed throughout their hospital stay by the same nurse case manager to streamline progression of care and advocate for the patient, consultants corraled these two professional groups into a newly created case management department. The nurses and social workers now worked in case management departments but had little or no understanding of the practice of hospital case management (HCM). The nurses continued performing customary UR, whereas the scope of the social worker evolved to include all DCP activities. I call this era of case management evolution, HCM v2.0.

Two versions of HCM v2.0 eventually surfaced. HCM v2.1 is what I refer to as the consolidated model with each professional group continuing to perform their UR and DCP tasks as previously practiced but within a single infrastructure and under the leadership of a single director. The incumbents had new job descriptions with titles such as SW case manager or nurse case manager. In larger hospitals using the HCM v2.1 structure, there is often a manager for the UR “division” of nurses and a manager for the SW “division” of social workers, which perpetuates the well-documented partition between the two disciplines. In HCM v2.1 departments, the staff members do not always perform as a team and generally lack a cohesive view of purpose. Everyone got new titles but continued the same functions—dependent and in parallel of each other.

HCM v2.2, on the contrary, integrated the UR tasks and DCP activities into a single role with a title of nurse case manager or case manager and generally required a registered nurse for the position. Integrating the tasks into a single role was often accompanied by a further downsizing and significant reductions in SW full-time equivalents. There are hospitals today that do not have any social workers on staff but instead use “contracted” services on an “as-needed” basis. There is little evidence that either HCM v2.1 or v2.2 incorporated any of the original principles expressed by Zander (1985) and practiced at New England (see Table 1).

Today, HCM v2.1 and HCM v2.2 models and various iterations are prevalent in hospitals across the country and hospital case management processes are largely defined in terms of the UR function or DCP activities. Unfortunately, in all but some large, innovative academic centers and progressive community hospitals, the practice of the case management process as originally envisioned is rare. It is nearly unknown among today’s hospital case management practitioners, who define case management in terms of the practical tasks associated with UR and DCP. And, as more and more chart review tasks are heaped upon the HCM, the theoretical practice of case management based on sound principles and strategic methods of managing progression of care fade into the background.

HCM v3.0 is a transformative model found in those organizations seeking to engage physicians, use resources more effectively, drive more efficient
progression of care, and demonstrate measurable outcomes to generate a return on investment. These organizations undergo massive cultural shift over 12–18 months often resulting in a case management staff turnover greater than 30% as the bar is raised on performance expectations. The pioneers who commit to the new model are typically career oriented, high achievers, enthusiastic boosters, and rarely afraid of change. Case manager positions that were, in the past, avoided by anyone familiar with the hospital’s previous functional model became highly desired positions with rare vacancies.

**PRACTICE DEFINED**

One does not have to go far to define case management practice. There are three professional organizations that have articulated definitions and standards of practice that should serve as a guide to every HCM leader and a hallmark of quality for every case management practitioner. In 2009, the Case management Society of America (CMSA) approved an updated definition that states that

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes. (CMSA, 2010, p. 8)

The Commission for Case Management Certification (CCCMC), the first and most prestigious case management certification agency, defines case management as follows:

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client’s health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. (Retrieved October 18, 2010, from http://www.ccmcertification.org/secondary.php?section=Case_Management; p. 1)

The American Case Management Association (ACMA), the professional organization for hospital and health system case managers, describes the practice of hospital case management as follows:

Case Management in Hospital and Health Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates
care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination. (ACMA, 2002)

The Leader’s Guide to Hospital Case Management (Daniels & Ramey, 2005), the first text devoted entirely to hospital case management, provides the following definition:

Acute care case management is a collaborative and facilitative process of business, interpersonal, and clinical strategies that, when successfully applied, effects more efficient delivery of care, reduces variations in the consumption of clinical resources, and produces improvements in clinical and financial outcomes. (p. 93)

However defined in the literature, on the Web, or in hospital marketing brochures, the intent of case management practice can be deduced from these four definitions. First, case management is meant to be a process that incorporates several elements of responsibilities. Second, its expressed intent is to ensure collaboration between patient and team members, to coordinate service along the continuum, to promote the patient’s progression of care, and to ensure that appropriate resources are being utilized, and that it generates objective outcomes. Although it sounds simple on paper, creating a model to achieve these lofty intentions is not without challenges. But it must start by abandoning the old mental models of what constitutes hospital case management practice and assimilating a new model that resonates across hospital case management communities.

**Extinguish Old Assumptions**

One of the more popular definitions of insanity is doing the same thing over and over again and expecting different results. In HCM, we may be suspect of meeting that definition. It is clear that what is labeled as case management practice in many organizations falls short of the definitions cited and the intended purpose. Doing what we have always done under the assumptions of the past will serve no one well; least of all, the patient and family/caregiver. The business of managing care has changed dramatically and what we have always done, no matter how good we are at doing it, will no longer suffice. We have to look to new and responsive ways of thinking, doing, and contributing.

**Venue Distinctions**

Is hospital case management different from other venues and does it warrant consideration of a distinct platform of principles and guidelines that separate it from its counterparts in the payer or community venues? I think it does and I base my belief on three major premises.

The first premise is the organizational attribute of clinical confluence. The hospital environment contains a whole host of clinical providers, expert in their field and accountable to the physician, the patient, and the organization. This confluence of clinical expertise at a single site brings the best of the clinical world to the bedside of the patient and precludes the inclination to place the HCM in a clinical role. There are some who would argue otherwise. They assert that excellent case management is first and foremost a clinical service (Zander, 2008). What would be the case manager’s clinical role? Would that role be complementary or redundant to those being provided by existing hospital clinicians? What clinical services will the case manager provide? Are those services new to the continuum of acute care or are they within the scope of practice or scope of care of other professional providers? I have
yet to encounter any new clinical service opportunities that can be best managed by an HCM. As a result, a halo of clinical ambiguity surrounds the typical HCM and is cause for tension, uncertainty, and role confusion.

The second premise is the issue of congruence. Congruence refers to the fit between the hospital’s case management program—its structure and processes—and the cultural and political realities of the hospital environment. The static character of the typical hospital case management department is fixed in a rigid cycle of task completion rather than the social and operational contexts of the hospital. Case management practice, however, cannot exist in isolation and must give consideration to the hospital’s strategic mission, its value system, its political systems, and its cultural beat.

Put another way, the case management program must modify its conceptual, structural, and operational framework to suit the political environment. By doing so, the case management program can secure a coherent shape to its structure and processes and discard, the trivia of the functional case management experience.

### TABLE 2

<table>
<thead>
<tr>
<th>Artificial Assumptions</th>
<th>The Reality</th>
</tr>
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<tbody>
<tr>
<td>Ancillary and service department managers develop delivery-of-care processes that are efficiently responsive to patient needs and the progression of care.</td>
<td>Ancillary and service departments design process and procedures that best serve the function of the department.</td>
</tr>
<tr>
<td>Physicians prescribe services, treatments, and care that are in the patient’s best interest and reflect evidence-based research.</td>
<td>Physicians prescribe interventions primarily on the basis of what they were taught in medical schools. Only 15% of medical interventions are based on the research.a</td>
</tr>
<tr>
<td>Patients receive adequate information to affect a safe transition to a lower level of care or discharge to home.</td>
<td>Information about transitions of care or post–acute care services is often fragmented with little evidence of accountability</td>
</tr>
<tr>
<td>Handoffs between physicians, case managers, service areas, nurses, and other clinical team members are efficient and safe.</td>
<td>Researchers at the University of Chicago cite that important information gets overlooked during physician-to-physician handoffs.</td>
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advocate for the patient and influence decisions that affect both clinical and financial outcomes. Because authority is a prerequisite for accountability, it must be gained through other means. The fact is that HCMs can influence others without any assigned position of authority or power. They do it by building positive relationships, by having the other person’s best interest in mind and respecting the other person’s needs and preferences, and by finding areas of mutual interest and honoring the law of reciprocation to create win-win situations.

I have come to accept that many well-intentioned case management programs may start off with the goal of providing proactive, progression-of-care case management, but fall short of their goals because of inadequate preparation of the case management profession, lack of understanding of relationship building, inadequate communication skills, and, too often, weak leadership with little knowledge of hospital case management practice. As Powell (2000) stated so succinctly, “nothing causes more frustration and burnout than a poorly trained worker; this was a leading cause of attrition of case managers in the early years.” It may have improved in the payer community as they gained greater sophistication in developing roles and services to meet the needs of their members. Unfortunately, the same is not true for hospital organizations. By default, hospital case management programs generally fall into the DCP, UR pattern of tasks offering little in the way of case management practice. The well-publicized risks of hospitalization are known to the public and media. Those of us whose careers have been hospital-based know that the publicized risks only scratch the surface. If HCMs are to fulfill their ethical obligation to advocate for the patient, then they must create the leverage needed to influence change on behalf of the patient—the intended beneficiary of every HCM’s practice.

BUILDING AN ADVOCACY PRACTICE

Most healthcare workers would find the suggestion of a hospital functioning as a well-tuned efficient organization rather ridiculous. Aside from frightening headlines about the wrong limb being amputated, or the death caused by incorrect dose of medication, there are very real structural and operational parameters, ones that have been codified and legalized, that are real obstacles to efficiency. Foremost among these is the archaic structure of the organization that creates two distinct and, oftentimes, conflicting bureaucratic hierarchies. On the one hand, there is the administrative structure led by a professional CEO responsible to a board of directors. This structure is concerned about the financial viability of the business and its reputation in the community.
On the other hand is the organized medical staff, a structure made up of physicians who may lack the business acumen to run a large corporation. The administrator views the hospital as a business, which must maintain itself economically; the physicians are primarily independent contractors who request the latest equipment (sometimes, regardless of cost) and expect the freedom to prescribe services deemed fit. The administrator knows that, unless the hospital remains financially viable, its service to the community may be sacrificed. Physicians know that they are free to prescribe anything they want to maintain their financial status and will not suffer any economic consequence even if the hospital does. The hospital may get denials for services that were not medically necessary, but the physicians’ reimbursement will not be affected. This entrenched and outdated infrastructure, which, admittedly, is slowly weakening with the growing population of employed physicians, places a cultural barrier between each interest group, which is difficult to overcome. In this reality, an HCM has little chance of success without entering into a partnership with each organizational branch. For the executives, the HCM team must be able to demonstrate its value to the financial bottom line. The team must demonstrate that it is well positioned to advocate for the hospital without compromising the primacy of its advocacy obligation to the patient. For the medical staff, the hospital case manager must be viewed as an asset to the physician’s practice. The physicians should want to embrace the HCM as complementing their practice, supporting their desire for good-quality care, protecting them against the scrutiny of external oversight agencies, and safeguarding their economic status. The case management program that successfully balances the needs of both branches will have created the leverage needed to serve as the patients’ primary advocate, to demonstrate value, and to thrive.

**Viewpoint Convergence**

The realities of these distinctions require a fresh look at both the static and dynamic views of hospital case management models. On paper, the static view is represented by the hospital’s table of organization and the way the program is organized. The dynamic view describes the behavior of individuals. The dynamic view is commonly described by flowcharts, workflow or process diagrams, policies and procedures, and standards. Sometimes a third view, which I call the reality view, should be used. The reality view is aimed at breaking down case management practice into manageable units with which to evaluate, explore, and consider alternative concepts that drive an outcome model.

The manageable units of most hospital case management programs are best identified by the patient’s trajectory through the hospital system (see Table 3). The dynamic phases of selection, assessment, planning, advocacy, and evaluation mark the patient’s journey through the continuum of care. Within each of these segments, the activities of the HCM may vary from hospital to hospital. For example, during the patient selection phase, the fundamental principle of ensuring that the patient is in the most appropriate venue to meet their immediate needs prevails. How it is translated into the HCM’s role, and responsibilities, however, may vary from hospital to hospital. What we do to help patients navigate across this trajectory is the basic premise of the process of hospital case management practice and must remain constant and inviolate. How we do it, however, is a product of each hospital’s unique character.

The reality view of the hospital environment belies a knee-jerk UR/DCP approach to model development. To be successful, a conceptual model must consider both the static and dynamic views of the program, but it also cannot ignore the reality of the political hierarchies, persons of power, awkward sentiments, cultural truths, and the opposing incentives that dramatically drive our health care system and govern our hospital lives.

**Building a New HCM Model**

We build model airplanes, we create model Sim Cities on our computers, and we model clay into the form that best reflects our internal vision. Models in health care can be compared to a blueprint, a theoretical/conceptual framework that reflects our vision and guides our practice. A model goes beyond the notion of an amalgamation of distinct tasks to the notion that it really is the product of the integration of several distinct practice phenomena. In the case of hospital case management, the model must connect the phenomena of multiple practice domains, such as collaboration, coordination, advocacy, facilitation, influence, learning, and negotiation, in accord with the cited principles of clinical confluence, congruency, and leverage. The resulting model is a complex, but integrated, system of many interacting variables that can be organized by categories of information that are critical to the practice of hospital case management. A common element of the general systems theory is the interaction of process components and the nonlinearity of those interactions. So too, the variables impacting each of the theoretical domains of case management practice are constantly interacting with the variables of the practice environment that encircle them all. Hence, a change in one effects
a change in all the others. The successful HCM strives to maintain an optimal balance not only within each of the practice phenomena identified in Table 3 but between them and the reality of the hospital milieu as well. The HCM plan must, therefore, be flexible enough to address each of the domains within the context of the medical treatment plan.

Conner (2006) states that shift happens and change occurs and that people have a choice to be either the master of change or the victim of it. He suggests that only a crisis—he uses the analogy of standing on a burning oil rig with no hope of rescue—will make people change. Our current disruptive environment, plagued with reimbursement shortfalls, persistent oversight, rapidly changing regulatory requirements and accreditation standards, demands for better quality and patient safety, and expectations of new technology, has created something akin to our standing on a burning oil platform and realizing that the normal solutions just will not work. Will we change or simply continue with the paradigms, models, and thinking that have brought us to the crisis?

What is called for is nothing short of transformation, a dramatic shift from ordinary change and business as usual (Drucker, 1998; Toffler & Toffler, 2006). No amount of “change management” will work if the objectives are flawed. It calls for the dramatic shifting of how we view the practice of hospital case management and how we conduct daily transactions within the hospital environment.

Characterizing and conceptualizing a standard HCM v3.0 model is a critical step in building one. A solid foundation requires consensus on the intent and must be based on best-available knowledge. A new conceptual model must present a distinct frame of reference, which represents a logically congruent compilation of the concepts and the future vision. In the traditional new model development process, thinking
broadly about a problem and generating several conceptual designs early in the process will lead to a better solution at the end. As noted, hospital case management, by its very nature, is governed by strong and omnipresent political, cultural, and social precedents and must depend upon the range and variety of experiential insights to understand the contrary and contradictory features that affect case management practice—without giving in to the temptation of theoretical doctrine.

Because we are burdened by a lack of understanding of just what constitutes hospital case management practice, model design efforts are a challenge, or at best, highly painful for many provider organizations that still consider UR and DCP as constituting the scope of case management practice. Too often we try to piece together the various components of a program, as envisioned by the executive group, without having created in our minds—or theirs—from the outset, a solid conceptual model of case management practice and how the model and design strategies will interrelate to achieve the desired outcomes. However, working from a base of concepts, such as those previously discussed, suggests that a broad view of the situation can be articulated to unravel the opportunities of a new environment.

I often cite an article that presents a great analogy that can be used to better understand the challenges arising from the lack of a standard conceptual model of hospital case management. Take the home stereo system; the article suggests.

Most of us can purchase a home stereo system, install it, then use it regularly. We can also expand an existing stereo system without difficulty by purchasing add-on components. We can even buy a single remote control that enables us to control all the equipment at the push of a button. The reason why we are able to do this is because we inherently understand a number of the key components that reflect the stereo’s operations. For example, we know that “volume” means how loud the sound is, and that every stereo system provides a way to boost or decrease sound. No matter what the volume control looks like or how it is operated, for any receiver from every manufacturer, the volume control provides the same function. Along with such functions as “on” or “off,” right speaker or left speaker, we seem to inherently know what to expect from any stereo system. This is because we carry in our heads, gained from life experience, a model for stereo systems, that we can apply to any specific system we see. The designers and manufacturers as well as the salesmen who sell it to us all share the basic model with us. This reference model enables us to map the specific stereo systems we see to a general model we already understand.” (Seliger, 2001, p. 22)

Unfortunately, when it comes to hospital case management programs, a standard reference model does not yet exist. Instead, we are left to evaluate each component on its own merits and guess how each strategy might fit with other elements of the program. This is a tedious and often error-prone approach, as our model may not jibe with the expectations of our various customers. Too often, we are left with a bundle of disjointed activities and tasks that struggle to be an integrated process.

Theoretical Assertions

For many years, experts in the field have argued that case management is neither a profession nor an academic discipline but rather a subspecialty of nursing practice. That posture may have been valid at the infancy of hospital case management development when it was indeed a variation of primary nursing practice (HCM v1.0). The argument, however, has lost standing with the evolution of hospital case management, the spate of academic programs in case management studies, and the introduction of nonnursing professionals into the community. Social workers, physicians, therapists, and other professional practitioners have continued to demonstrate their ability to tackle HCM challenges in large and small facilities. If nursing theories no longer apply, how then do we validate hospital case management practice?

During every hospital engagement, HCMs in practice were asked to complete surveys about their practice. The survey consists of both a Likert scale to ascribe quantitative value to qualitative data and open-ended questions to gauge the HCM’s understanding of the intent of the hospital’s case management program, the expectations of the HCM role, and the degree of preparation they had for the role. A final question, and most telling of all, is “how do you know that you are making a difference?” Responses collected over the years have led to the development of a list of theoretical assertions about the practice of hospital case management from the perspective of the staff member. These are retroductive inferences based on my professional experiences.

1. HCMs are proactive patient care advocates.
2. HCMs serve as facilitators and patient care navigators to promote progression of care.
3. HCMs proactively engage members of the medical staff to help them better understand the nuances of quality, reimbursement, risk, and customer satisfaction.
4. HCMs are valued as consistent resources to the patient, family, and clinical team to keep progression of care moving forward.
5. HCMs are knowledgeable about the rules and regulations governing hospital operations and

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6. HCMs have front-line knowledge of progression-of-care gaps and obstacles.
7. HCMs are able to overcome roadblocks to progression of care so that the patient is minimally exposed to the iatrogenic risk of hospitalization.
8. HCMs seek and maintain current knowledge about advances in evidence-based medical practice.
9. HCMs proactively anticipate post-acute care needs and take necessary steps to put into action.
10. HCMs partner with nurses, doctors, and other professionals to promote quality-of-care standards through knowledge of evidence-based protocols, nationally recognized level of care criteria, core measures of quality, hospitals consumer assessment of healthcare providers and systems, and other similar quality outcomes.
11. HCMs demonstrate their value with measurable outcomes.

As a set of theoretical assertions, they are best viewed as a series of connected concepts explaining the practice of hospital case management. They must also be viewed as practices that the HCMs interviewed aspire to assume. They challenge the current reality of HCM practice and reflect the new reality of the hospital world that we have to live with, not the one that we already know and that we are comfortable with. Furthermore, they represent measurable value to and for our patients, our customers, and our community. Most importantly, however, is that to produce a viable and widely applicable model of HCM, these foundational concepts can be used to proactively create new initiatives to take us into the future. And as Drucker has noted in many of his writings, if you can't predict the future, create it.

SELECTIVE REVIEW OF THE LITERATURE

A compelling research study was published 5 years ago that included an extensive literature search on acute care case management models. Through an analysis of the literature on hospital models, Terra (2007) concluded that, although there is no single case management model that can be identified as a “preferred” one, there is adequate evidence-based literature to acknowledge key factors driving the acute care model. Those factors, extrapolated from the extensive literature, include the following:

- The preferred case management model results in measurable outcomes that can directly relate to, and demonstrate alignment with, organization strategy.
- Monitoring the delivery of patient care against evidence-based treatment guidelines can identify opportunities to facilitate the provision of services.
- An effective integrated program includes both SW and nursing.
- Patient and family contact is a required component of any hospital case management model.
- A successful case management model will recognize physicians as valued customers with whom partnership can positively affect outcomes.

It is heartening to note that these key factors are quite similar to the assertions that arise from my experience and validate my perspective.

COMMISSION FOR CASE MANAGER CERTIFICATION’S STUDY

Every 5 years, the CCMC conducts a national role and function study to identify knowledge domains and essential activities of case management practice to ensure that the national certification examination reflects the current state of case management practice (Tahan & Campagna, 2010). Of the 6,950 participants who submitted a practice survey, 22.8% reported hospitals as their primary work setting giving the findings a high degree of hospital case management relevancy.

The Commission’s practice analysis study is the critical foundation for developing a psychometrically sound and legally defensible credentialing examination. The analysis seeks to ensure that the examination for certified case manager is content valid and that it appropriately evaluates what is required to function as a competent practitioner in the field. The analysis addresses the domains of role, function, activity, and knowledge, and the representative statements were developed by experts in the field on the basis of essential activities and knowledge areas that the experts believed were important to the daily work performed by case managers in various settings (Tahan & Campagna, 2010). The results of the analysis indicate that hospital case management practice has assimilated many of the phenomena listed as essential activities. However, my observations of actual hospital case management do not bear this out. In fact, I sense a wide gap between professionally influenced discourse, presumably intended to guide practice, and extent organizational factors that create a dissonance for case managers. Despite these reservations, for the most part, many of the statements used in the survey are exquisitely applicable to hospital case management practice. Coupled with Terra’s study and empirical research from the field, they can be used to formulate a standard hospital case management model.

EVIDENCE-BASED PRACTICE

Following the 2004 CCMC study, a project was undertaken to determine which activities and knowledge areas are generic across professions and CM work settings and which are specific to professions and
CM work settings (Park, Huber, & Tahan, 2009). Using the data set from the 2004 Role and Function Study, the researchers found that several questionnaire items were specific to hospital-based practice whereas others were not essential to case management in hospitals and rehabilitation facilities (Park et al., 2009). Even more telling was the finding that the “least agreed-on pattern of generic, specific, basic, and nonessential activities and knowledge sets was found between hospital settings, and either case management companies or workers’ compensation agencies.” These findings led the researchers to assert that it appeared that the activities and case management as it is practiced in hospital settings are different from those in other work settings (Park et al., 2009). This conclusion supports the position that hospital case management practice warrants a standard set of principles upon which a model can be designed.

**Defining a Conceptual Model for the Practice of Hospital Case Management**

As hospital case management programs strive to achieve improvements in quality, effectiveness, and efficiency, there is a need for coherent conceptual frameworks to describe hospital case management practice. This conceptual framework for hospital case management practice is grounded in professional standards, evidence-based research, and empirical confirmation, and is based on Donabedian’s now classic “structure + process = outcome” model. Donabedian unraveled the mystery of quality care by demonstrating that quality is an attribute of a system that he called structure, a set of organized activities that he called process, and an outcome that results from both. This model has been used over four decades by many health care organizations to evaluate performance (Rossi & Freeman, 1993).

Donabedian’s model is sufficiently broad to construct a framework for the process of hospital case management and is a practical and useful tool to standardize role, function, and knowledge domains.

**The HCM Framework**

The HCM framework has four core components: advocacy; structure and operations; progression of care; and value.

**Advocacy**

Advocacy is the hospital case manager’s primary ethical obligation. More than any other practice venue, advocacy in the hospital is essential. The nature of the hospital, its dominant medical culture, Tayloresque infrastructure, and imperfect processes of care delivery illustrate an environment of controlled chaos with the traditionally passive patient at its core, subject to startling and well-publicized consequences (Daniels, 2009). Advocacy must be at the core of every HCM practice behavior. It drives the case managers’ need to see to it that individuals who are inpatient-qualified are admitted to the hospital so that those whose needs can be more safely met in an outpatient venue are not exposed to the iatrogenic risk of hospitalization. It is the motivation to query medical interventions that may be contrary to evidence-based protocols or may not be in the patient’s best clinical or financial interest. It is the stimulus that keeps the HCM visible and present on the patient units to ensure that progression of care moves forward and that any real or potential obstacles are addressed immediately. It is the incentive to partner with the patient’s clinical team caring for the patient to stay abreast of the medical goals and treatment plan. It is the summons to consider the economic issues associated with every medical practice decision.
or noncontributory, and every avoidable day that the hospital warehouses patients and increases their risk for an adverse event.

Advocacy must be proactive; the HCM must anticipate clinical, financial, or psychosocial issues and take action to address them before they become impediments to high-quality, safe, and cost-effective progression of care. Advocacy is not limited to the patient. There are multiple stakeholders that are impacted by the success or failure of the patient’s progression of care. The patient may suffer clinically or financially. The physician may come under public scrutiny and suffer financial loses. The hospital may endure the consequences of lost revenue, lost reputation, or lost referrals. In the end, the community as a whole undergoes traumatic upheaval should the hospital fail and cease to exist.

A proactive advocacy model necessitates several adaptive responses in role and function. Foremost among these is the need to identify selected patients whose situations warrant advocacy greater than that provided by the primary nurse. To that end, there must be a methodology to identify patients for HCM services. Screening inpatients for assertive HCM oversight neither requires a comprehensive assessment of every patient, nor do standards of practice compel a full-blown assessment for every inpatient. The clinical team has already produced two: (1) every patient must have a history and physical examination performed by the admitting physician and (2) every patient must undergo a nurse-initiated initial patient assessment upon admission. Both of these documents have information that would serve as a first-level screening process to identify patients who would benefit from comprehensive HCM services.

With the advent of electronic medical records, both of these documents can be technologically mapped. Mapping refers to the ability for software to move specific bits of information from the source to the destination. In this case, selected “hotspots” on the history and physical examination or initial patient assessment can trigger a case manager referral. Those “hotspots” may include such data fields as age, living situation, previous home care services, self-care deficits, previous admissions, cognitive defects, sociologic issues, history of alcohol or drugs use, chronic illnesses, and other factors that, taken singularly or in combination, may warrant intensive case management intervention. Only then does a comprehensive assessment for case management services need to be completed. The idea that every patient needs case management services is one that must be eradicated. Just as every patient has access to a physical therapist if warranted by the patient’s functional status, so too, every patient has access to an HCM if warranted by possible or anticipated progression-of-care issues that can be most efficiently identified through the clinicians’ assessment.

Structure and Operations

Donabedian’s “structure” refers to the stable elements needed to establish, implement, and maintain order to operate. It includes the hospital’s mission, its vision as a health provider, organizational goals, attributes of material resources, human resources, organizational structure, policies and procedures, job descriptions, physical space, staff knowledge, skills, competencies and training, staff deployment, financial management, information systems, and the capacity of the program to meet the needs of the patients served.

Among the structural and operational elements, two stand out as ripe for standardization. First, job descriptions are as varied as there are hospitals, but should contain a core group of functions that does not deviate from the largest academic center to the smallest critical access hospital. Those core functions are derived from the essential activities that reflect the HCM’s oversight of progression of care from access to transition. In addition, the time has come to discard the assumption that eligibility for an HCM position requires a registered nurse license. As the literature demonstrates, HCMs come from many disciplines and candidates should not be disqualified on the basis of eligibility criteria, but on their ability to fulfill the role and responsibilities.

The second element that cries out for standardization is the removal of the UR function from the HCM role. The customary chart review activities that comprise the UR function should not be confused with resource management. Ritualistic chart reviews to provide information to the payer or to uncover or obtain documentation that provides evidence that the patient meets acute level criteria is a retrospective activity—the thing has been written; the thing has been done (Daniels, 2000). Resource management, on the contrary, is the intervention of the HCM to prevent an unwanted event from occurring in the first place.

In many hospitals, the customary chart review activities that comprise UR activities were integrated into the HCM role in the early 1990s when UR departments were combined with social service departments to create case management departments. In organizations that emulated the clinical nurse case management models, of which there were few, New England, Toronto, Carondolet among them, the argument to integrate case management and UR services appeared in the literature with the new century. One article argued that the potential benefits include the following (Kelly, 2001):
Progression of care demands real-time patient management and is best accomplished in concert with the physician and the clinical team to address and resolve immediate progression-of-care issues.

- Greater efficiency by reducing duplication of effort
- Increase referrals by minimizing the barriers
- Improve patient care
- Reduced case costs

Similarly, Zander (2009) identifies UR as a core function of case management services. Neither author implies that the UR function should be incorporated into the HCM role. The difference may be subtle, but it is very real; the role of the case manager refers to the activities that the HCM performs, whereas case management services refer to the activities performed under the auspices of the case management department. Medical necessity determinations for acute level of care are under siege. What was once a process of perfunctorily endorsing physician orders for an inpatient admission has become a war between physicians, government, hospitals, and insurers. In the past, it was the commercial insurers whose previous interest in progression of care was tepid, at best. However, the federal oversight agencies and their contractors are closely scrutinizing Medicare and Medicaid patients to confirm acute level of care necessity. What was once a process of perfunctorily endorsing physician orders for an inpatient admission has become a war between physicians, government, hospitals, and insurers. In the past, it was the commercial insurers whose previous interest in progression of care was tepid, at best.

Progression of Care

Progression of care equates to Donabedian’s process and refers to the interactions between the HCM and members of the clinical team who drive progression-of-care efficacy and, ultimately, outcomes. A successful interaction results in an effective progression of care that is timely and responsive to patient/ family preferences and skillfully applies safety protocols and guidelines, algorithms, or critical paths to ensure evidence-based medical interventions. Progression of care demands real-time patient management and is best accomplished in concert with the physician and the clinical team to address and resolve immediate progression-of-care issues. In a compelling German study testing the efficacy of a “length of stay—oriented case management” model, the authors state:

Generally, a patient is looking toward a hospital stay that is as short as possible. Hence, medical processes should also be structured in a way that unnecessary extension of hospital stays can be avoided in order to achieve an optimal result, both economically and qualitatively. A commensurate control of the treatment process can be described as case management. (Researchers’ italics; Kainzinger, Raible, Pietrek, Muller-Nordhorn, & Willich, 2010)

In describing the intervention and control methodology used in the investigation, the researchers report that the HCM and the physician establish a working DRG and set a target discharge day. The HCM has no other duties besides case management and the physician establishes a working DRG and set a target discharge day. The HCM has no other duties besides case management responsibilities for optimally coordinating the treatment process. The model experiment was driven by the organization’s desire to eliminate unnecessary extensions of length of stay and to provide transparency of the entire treatment process. The length of stay for the intervention group averaged 5.89 compared with the control group of 7.34. In addition, readmissions within 30 days was 1.45% in the control group and 0.60% in the intervention group and new revenue resulting from increased bed availability was appreciably increased (Kainzinger et al., 2010).

There are three key issues that influence progression of care. Two are physician related and the third relates to organizational systems.

1. The volume and intensity of prescribed medical interventions account for upward of 80% of clinical costs and affect the progression of care and, ultimately, the patient’s length of stay.
The extent to which care is consistent with professional knowledge is accomplished by examining adherence to protocols and guidelines. For many years, it was argued that monitoring variance is the best way to evaluate adherence. However, I do not believe that the HCM should ever be put in the situation of policing medical practice. It is a sure-fire way to quash any chance of building a positive partnership. Rather, using their knowledge of clinical protocols, pathways, or algorithms, HCMs can refer to them during discussions about medical goals and treatment plans. It is the ability to influence the use of evidence-based medical practice that represents the dimension of proactive advocacy. It may not change the physician’s habits overnight, but perseverance will often win out.

2. Practice profiling is an objective method of detailing the patients’ progression of care. It enables the case manager and the physician to compare patterns of resource utilization for a defined patient diagnostic group with peer groups and regional benchmarks and ultimately use the information to self-modify practice behavior. Hospital case managers should have access to this valuable resource if they are expected to influence variable costs per case.

3. Delivery-of-care processes refer to the ability of the clinical team to render care and services prescribed by a physician in an efficient manner. Inefficient delivery of care is the primary cause of extended lengths of stay, avoidable days, and unnecessary exposure to iatrogenic risks. Over the years, hospitals have centralized virtually all ancillary and service functions. While many can be dispatched to the bedside, by and large, we move the patient or a specimen to a central area for service. A natural outgrowth of this model is that elaborate scheduling and transportation work is needed to perform each function. The hidden costs of compartmentalization are enormous and the industry has invested millions of dollars to overcome the inefficiencies. Yet these are the obstacles that nurses, physicians, and patients confront every day. It is the HCMs who, wearing their advocacy hats, must exert influence to drive performance improvement and bring to the attention of all hospital employees their role in safe patient care. Capturing, quantifying, and disseminating information about delivery-of-care process weaknesses, accompanied by one-on-one dialogue with the process owners, will promote a team approach to organizational improvements.

Outcomes

The term outcome management was coined by Paul Ellwood, MD, chairman of InterStudy, a health care think tank in Excelsior, MN. The outcome is the final result of the case management process and is the concluding component of Donabedian’s seminal work on the concept of quality. In medicine, physicians seek to demonstrate, in an evidence-based fashion, better outcomes for a specific medical option. In hospital case management model development, it asks the question “what metric is used for determining the impact of a process or intervention on economic, clinical, and operational outcomes?”

When Zander (1985) revolutionized primary care nursing at NEMC, she and her team transformed the practice of nursing to an outcome-based practice in the form of case management. As case management morphed into a discipline separate from nursing practice, Daniels and Ramey (2005) described the latest iteration of HCM evolution as an outcome model. These references to outcomes reflect the growing demand for measurable results. However, the rush to embrace outcomes often ignores whether there is empirical evidence that the interventions HCMs have to offer actually affect the outcomes that are measured. It is, therefore, important not to reach false conclusions, as all the dynamics, the differences, and the variability on how hospital case management is practiced must be taken into consideration.

Assessing the outcomes of case management practice requires specialized knowledge of statistics, databases, and electronic mapping. It is intended to examine the outcomes of practice relative to the processes used by the HCM. Hospitals from coast to coast typically rely on length of stay as a barometer of HCM effectiveness. However, LOS is a legacy indicator that can be helpful to identify inefficiency of care, but it is seldom helpful in identifying the causes of inefficiency. And because, as previously stated, HCMs have no positional authority to discharge a patient or speed up the results of the final diagnostic test, it is a flawed metric with which to assess the value of a hospital’s case managers’ influence (Daniels, 2008). Instead, HCM programs must look to develop a compendium of outcomes that reflects the entire span of the case management process including the ability to demonstrate what impact the dynamics of practice have had upon the health status of the patients served.

Taken together, these two dimensions of outcome measurement, benefits derived from the case management process and patient benefits, serve as the foundation of developing a representative scorecard. Zander said it best when she stated that “In the case management world, a deliverable is the same as
a goal, target, outcome or result, depending on the language of the organization" (Zander, 2008, p. 70).

Because HCMs have no legal authority, outcomes result from their ability to influence members of the clinical team. They cannot control a physician’s decision to hospitalize a patient, but they can exercise influence to promote the most appropriate level of care assignment; they cannot control case-mix index but they can influence medical documentation through real-time, point-of-service coaching; and contrary to some published assertions, HCMs do not have direct control over length of stay, denial prevention, flow and capacity, or readmission rates. They do, however, have an ethical obligation to proactively intervene to influence these dynamics to advocate for the community stakeholders.

One of the methodologies used to develop relevant indicators is to use the trajectory of the acute care experience. If successful progression of care is a product of the entire HCM process, then case management practice interventions adopted for each of the phases of the typical acute care episode, access, throughput/care Management, and disposition can be used to measure cause and effect (see Figure 2). Case management operations and practice may differ for each phase of the trajectory. But the application of relevant concepts and principles that distinguish practice during each of these three phases will result in a measurable confirmation of a direct cause and effect of case management influence.

For example, in the Access phase, the emergency department HCM can influence the correctness of the level of care assignment. Whether through the use of a case management protocol or collaborative discussions with a physician who must first determine patients’ need for hospital level of care, the real-time influence of the emergency department HCM will directly result in an accurate level of care assignment at the moment it is determined that the patient needs hospital level of care. Similarly, the HCM’s influence during the throughput or care management phase might be measured in terms of resource consumption among patients with comparable diagnoses. When HCMs enter into bedside discussions with the physician about the treatment plan, they also use that opportunity to query the value of medical options prescribed and whether or not it is in accordance with the evidence-based protocol or order set. The results are resource utilization profiles that will confirm a slow, but steady, decrease in extraneous or unnecessary medical interventions that are a direct result of the HCM’s influence. There are many other financial, clinical, and operational metrics that are used to objectively quantify the HCM’s influence on progression of care. It is incumbent on each program director to ensure that the worth of the program consistently reflects the hospitals’ mission and core values, demonstrates support of quality and safety goals, meets the expectations of the customers it serves, and justifies its continued support.

Because the role and functions of case managers lack standardization, the success of HCM relies largely on case managers’ individual capabilities rather than on clearly specified roles and functions (Newcomer, Arnsberg, & Zhand, 1997, cited in Park et al., 2009). Lack of standardization is also the primary obstacle to developing an evidence-based hospital case management practice, and it constrains any comparative research to identify best practice. How, for example, will we ever discover what constitutes the best staffing ratios when we are unable to ensure that we are comparing the proverbial apples to apples. This restriction may be our greatest threat as we continue to evolve as a profession. Donabedian recognized that outcomes are impacted not only by processes but also by the structure in which services are provided. If marked differences in processes and structure continue in hospital case management...
programs, then evidence-based practice will continue to elude us as a professional discipline. Any sustainable improvements in HCM outcomes must come from the transformation and standardization of the design of practice components. That is not to say that every hospital case management model must replicate every other model. Rather, the basic principles governing the practice of case management in hospitals (recall, the reference model of a stereo system) must be standard (Figure 3), while each hospital independently determines how to best operationalize that standard (the various manufacturers of stereo systems).

**SUMMARY**

Working with HCMs since the mid-1980s, I have discovered that many lack an understanding of the historical factors influencing the practice of hospital case management and fewer still understand how to translate the standards of case management practice into practical application in the hospital environment. The absence of a standard model inhibits research and comparative studies and will undermine the discipline’s growth to meet new challenges. To sit at the executive planning table to discuss accountable care organizations, transitions of care initiatives, medical homes, physician practice purchases, revenue cycle improvements, value-based purchasing, and society’s demand for safe hospital care, hospital case management programs must move from a task orientation to proactive, progression-of-care practice. A standard progression-of-care outcome model that integrates knowledge steeped in organizational development, behavioral science, and the cultural context of the hospital environment represents a practical theory of hospital case management.

From firsthand experiences of hospital case management from its inception and from personal study of the social and political landscapes that define organizational culture, a standard hospital case management model that positions the HCM as the patients’ primary navigator and proactive advocate to promote a safe progression of care is the optimum model to achieve measurable outcomes and to ensure hospital case management’s position as changes in the hospital industry continue to escalate.

**REFERENCES**


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