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Creating a New Model of Care by Integrating Case Management Nurses in a Children's Hospital

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ABSTRACT

Purpose/Objectives: Nurse case managers (NCMs) have been identified as effective members of a care team in the development of effective and successful discharge plans. A pediatric hospital had an opportunity to change the model of case management (CM) in response to multiple initiatives. This article describes the process, barriers, and results of the integration of a new role into the care team.

Primary Practice Setting: The role development and integration were done at a quaternary-level pediatric hospital.

Findings /Conclusions: Introduction of the NCM role was accomplished through a multidisciplinary approach that employed continuous improvement, involvement of team and hospital leaders, and collaboration across multiple professions. The role was developed from one pilot to the eventual positioning of nine NCMs. Introduction of the new program resulted in a shift from a reactive dyad model of social worker–utilization management nurse to a proactive triad model of NCM–social worker–utilization management nurse. Success was measured by a decrease in the number of denials and an increase in the overturn of the denials received. Other results included the innovation of several processes that streamlined discharge planning and contributed to patient/family satisfaction.

Implications for Case Management Practice: Creation of a new nurse-led CM triad team can be accomplished through multidisciplinary support and a focus on continuous improvement. Further collaboration on discharge planning standards and CM is indicated. Additional research focused on the impact of nurse-led pediatric discharge planning as it relates to readmission reduction and appropriateness of level of care and length of stay is also needed.

Key words: *case management, dyad model, nurse, triad model*

Hospital case management (CM) has become a deep-rooted and efficient part of patient care, from preadmission to postdischarge. Early in the 20th century, CM evolved to provide integrated care for people in lower socioeconomic groups, across both health and social services (Kelly et al., 2019). The changing landscape of medicine, technology, insurance reimbursement, and managed care added to the complexity of health care delivery and created opportunities for nurses to combine clinical expertise with fiscal responsibility (Zander, 2002). Consistent features of this role include effective resource mobilization and coordination or continuity of care needs (Case Management Society of America, 2020). The most common features of pediatric CM are focused around resource utilization management, the attainment of authorizations from insurers, and discharge planning, most often led by a nurse (Campagna & Stanton, 2010). Models can describe team composition, such as a dyad versus triad, or the model can describe the function, such as immersive/comprehensive versus one in which the case manager becomes involved at the behest of a hospitalist (Poling, 2012).

A freestanding, Magnet-recognized, quaternary-level children's hospital in the northeast United States, located in a unique four-state intersection and serving as a national and international referral center for specific programs, has experienced exponential growth over the past three to four decades, moving from an orthopedic hospital to a full-service children's hospital. Throughout this period of growth, programs, services, and teams with a focus on excellence in child- and family-centered care, continuous

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Introduction of the new program resulted in a shift from a reactive dyad model of social worker–utilization management nurse to a proactive triad model of NCM–social worker–utilization management nurse. Success was measured by a decrease in the number of denials and an increase in the overturn of the denials received.

improvement (CI), and quality assurance have been developed.

The original dyad model that existed in this children's hospital consisted of a utilization management nurse (UMN) and a social worker (SW). The UMNs conducted clinical reviews of patient charts and provided written submissions to the relevant insurance companies; they also identified delays in progression of care and reimbursement denials. Within the dyad model, the bedside care team managed discharge planning with support of the unit-based or team-based SW, who also provided social services for patients. However, some issues with this configuration of teams included silos that did not always communicate effectively across disciplines, lack of clarity on discharge plans, and lack of procedures for the escalation of unresolved issues. As the health system grew, so did the number of concerns, highlighting both internal and external factors that affected workflow. In 2010, the Affordable Care Act was enacted, with most provisions in effect by 2014; (U.S. Centers for Medicare & Medicaid Services, 2020). In response, insurers, both commercial and Medicaid managed care organizations, changed the way they viewed reimbursement and levels of care, emphasizing more observation care and discharges to home earlier in the course of illness (Woodward & Rice, 2015).

This children's health system, dedicated to the care of all children within geographical reach and with an eye to a changing environment, committed to working on a value-based model, developed to embody a quadruple aim, which includes improving the health of the population served, enhancing the patient experience, reducing the cost of care, and care team well-being (Bodenheimer & Sinsky, 2014). Success of this aim is indicated by meeting measured metrics, such as readmission rate, length of stay, and resource utilization.

A heightened focus on length of stay, sustainable/successful discharges, and readmission reduction was needed in a patient-facing approach to meet these metrics. The existing CM model was siloed and reactive, as opposed to anticipatory and collaborative in practice. The care team involved the SW on or near discharge to request services and discharge assistance. These SWs would fulfill these tasks while also meeting the psychosocial needs of vulnerable patients and families, creating delays in task fulfillment. The electronic medical record offered UMNs the opportunity to complete reviews remotely from patients, making communication with bedside teams awkward and difficult.

Design/Description

A proposal was designed to introduce nurse case managers (NCMs) to the interprofessional team, visioned on merging the clinical world with the financial and providing crucial information to pertinent groups. Adding the newer NCM role to the group allowed for the creation of triad model: the NCM, the SW, and the UMN. As a nurse, the case manager understands the usual progression of care for specific populations, allowing any impediments to be anticipated and managed efficiently. The NCM would partner with the family and strategically oversee the development of a multidisciplinary discharge path while also tactically instituting the plan in a proactive manner. This proposal was presented to key stakeholders in the clinical and business teams of the hospital. A pilot of one NCM was approved with a plan to evaluate prior to the introduction of any future positions.

Utilizing evidence for this role was difficult, as the vast majority of CM models are built on adult inpatient care management, with limited information available regarding the unique aspects of pediatric CM (Holland et al., 2016). Known distinct differences between adult and pediatric CM include those listed in Table 1.

Connections with several children's hospitals to discuss models of care delivery and CM offered some assistance. An early iteration of levels of need for CM was shared by another children's hospital, and we adapted those levels to evaluate productivity (personal correspondence with Kristen Crammer, MSN, RN, CPNP, PCNS-BC, NEA-BC, Director Case Management, Egleston and Scottish Rite Hospitals, Atlanta, GA). The pilot planning committee also looked to professional membership associations for alignment with a national group and chose one focused on hospital and transitions-of-care CM. The next step was to determine which unit to pilot this position.

Through a CI event in the Cardiac Center around efficient discharge planning, it was determined that there was not a singular individual responsible for the oversight and successful completion of the discharge process. Rather, discharge planning was a shared

TABLE 1
Comparison of Differences Between Adult and Pediatric Case Management

Focus	Adult Hospitals	Pediatric Hospitals
Direction of care and decisions	Individuals have self-determination with family support	Children are dependent on others for informed decision-making
Etiology of illness and disease management	Lifestyle influences contribute to wellness and disease progression Self-management of health is encouraged	Entire family is impacted by illness and disease management
Insurance	Medicare rules and regulations underpin billing and reimbursement	While there are some children covered by Medicare, Medicaid is the largest health insurer for children (Children's Hospital Association, 2020)
Postdischarge transitional facilities	Multiple rehabilitation centers and nursing homes for short-term placements	Fewer facilities for short- and long-term placements
Medical complexity	Adults can sometimes manage own care with support of family or home nursing	Children are more dependent—The addition of technology dependence requires more highly trained home nursing
Psychiatric illness management: Both adult and pediatric populations are covered differently for behavioral health by insurers	A need for increased access and availability remains for adults	Mental illness often first presents in childhood, yet there remains a scarcity of outpatient and inpatient facilities Medical comorbid illnesses make placement challenging

responsibility, which often led to unclear communication and incomplete tasks. The timing of this CI event dovetailed with the approval of the pilot NCM recruitment for this new position. The project gathered a multidisciplinary group to interview candidates and to encourage leadership support of the role within the unit.

An experienced NCM who had all of the desirable traits and skills was recruited. As the CI process includes constant reassessment and frequent check-ins, the project lead and the new NCM made adjustments to the role during the immersive orientation. Unit and provider education around the NCM role was conducted and included the CI team to establish her role and efficacy. Initially, there was a natural concern regarding task handoffs and responsibilities that had previously been done by an SW, but the CI process allowed the team to determine which member of the group would be accountable and/or responsible for each step in the discharge process. The CI team assisted the newly formed triad in determining roles, specifically around tasks and responsibilities of the discharge process, such as obtaining prior insurance authorization for medications, procurement of durable medical equipment vendors, and organizing team/family meetings. One specific CI event that was especially useful was the RACI, which identifies who on the team is (R) responsible for a task, who is (A) accountable, who needs to be (C) consulted, and who needs to be (I) informed. The process of mutually identifying and clarifying roles for each task was essential to the eventual cohesiveness of the new triad.

The next step involved determining metrics that would prove effectiveness of the new NCM role. Evidence review indicated that there was not one uniform method of evaluating productivity or efficacy. The utilization management department already had a robust measure of the rate of insurance denials. A metric that had previously been difficult to establish was the clear identification of all barriers to progression of care resulting in avoidable inpatient days, revolving around avoidable inpatient days or those days in which a patient remains in a hospital bed with no true medical necessity An example is a patient awaiting surgical placement of a gastrostomy tube but for whom surgery has been delayed because of scheduling issues, not medical ones. Such delays negatively impact length of stay and denials by insurers.

An orientation plan for the NCM was developed and included involvement of the social work team, a framework of guiding principles, professional standards, and a forum in which to find solutions for problems/issues that may arise. Although the SW was involved in orienting the NCM, this new role would be differently nuanced. The guiding professional standards and principles were adapted from the American Case Management Association (2020), which has a comprehensive didactic training system involving self-paced learning modules that encompass professional, legal, ethical, and compliance standards. This system also provides the case manager with the opportunity to enhance learning through concrete examples to apply principles and techniques (American Case Management Association, 2020). The hospital purchased a subscription to this learning system and, over the years, has found it to be an excellent way to onboard and begin orientation for new NCMs and ensure a consistent baseline level of knowledge.

The NCM tracked the rate of insurance denials, rates of denials overturned, the number of actual avoidable inpatient days, the number of potential avoidable inpatient days on which she was able to intervene, and length of time from identification of barrier to resolution.

The NCM immediately began attending daily patient care rounds, staff meetings, and morning huddles. The NCM met and worked with the bedside care team to learn how the Cardiac Center managed patients, preadmissions, progression of care, and discharges. Weekly meetings with the SW were key in managing shared responsibilities, potentials for miscommunications, and preventing duplication of efforts. Role ambiguity and confusion are expected when adding a care team member, but degree and effects can be managed (Smith, 2011). The new NCM and her supervisor/project lead also met weekly with the medical director of the Cardiac Center to collaborate on role development and to communicate provider-related issues. Nursing leaders were kept informed of all developments in the process. The NCM tracked the rate of insurance denials, rates of denials overturned, the number of actual avoidable inpatient days, the number of potential avoidable inpatient days on which she was able to intervene, and length of time from identification of barrier to resolution. The new triad model allows the UMN to continue the utilization review of patients' charts, but enhanced communication with the NCM around clinical progress more fully informs her reviews. The triad model also allows the SW to spend more time supporting a family's psychosocial needs.

The Cardiac Center has a combined census between the cardiac intensive care unit (CICU) and the step-down unit of 26–30 patients, which is a population fitting within benchmarked caseloads in other hospitals. Children born with congenital heart defects can have admissions from a few days to several months in the CICU and step-down units, depending on the complexity of the heart anomalies and the presence of any comorbid conditions. On average, the cost for 1 day in the CICU can be $7,000–$12,000 and 1 day in the step-down unit can cost between $3,000 and $6,000; therefore, an important part of managing cost of care is ensuring the appropriate level of care is assigned throughout the inpatient stays. The NCM and the UMN conferred to ensure that level of care was based on appropriate evidence-based criteria used by the hospital to evaluate medical necessity. It was decided that the NCM would meet patients admitted to the CICU and participate in the intensivist rounds one or two times per week, but the bulk of the work would be focused on patients transitioned to the step-down unit, rounding with this care team the majority of the week.

The first-year evaluation process for the NCM model indicated, not only improved metrics around denials management but also found multiple processes that required revisions. Sometimes, clearer documentation was indicated, which resulted in less denials by insurers. When a denial was received, having a nurse with knowledge of evidence-based criteria to support the provider during the peer-to-peer review resulted in providers more willing to conduct such reviews. By participating in daily medical rounds, the NCM was able to introduce any barriers in real time to the rest of the multidisciplinary care team. The introduction of these specific barriers to clinicians during rounds was novel for the care team and fostered timely resolutions. Table 2 includes data regarding denied and recovered days comparing 2017 and 2018, without and with the NCM role in place.

Hospital Implications

Although introduction of the NCM role was not initially accepted by all, when the original discharge improvement team met to evaluate progress of this pilot, there was unanimous agreement that the NCM role not only was value-adding and integral to smooth discharge

TABLE 2
Peer-to-Peer Reviews/Overturns

	2017			2018		
	Cases	Denied Days	Recovered Days	Cases	Denied Days	Recovered Days
Jan	1	2	2	5	23	23
Feb	1	1	0	0	0	0
Mar	1	2	0	1	3	3
Apr	4	24	8	1	3	3
May	4	49	13	1	3	3
Jun	0	0	0	1	2	0
Jul	1	2	2	0	0	0
Aug	2	3	1	1	2	2
Sep	2	5	2	1	2	2
Oct	2	5	4	1	5	5
Nov	12	105	103	0	0	0
Dec	1	2	2	0	0	0
Total	31	200	137	12	43	41
			68%[a]			95%[b]

[a]65% (2017) without nurse case managers.
[b]95% (2018) with nurse case managers.

Upon both financial and quality success of the NCM role and the triad model of care in the Cardiac Center, the original stakeholders met again to develop a plan to add more NCMs. Over the next 24 months, new NCMs were slowly introduced throughout the hospital.

planning but also had quickly become critical to the rest of the care team for its singular focus on improved patient outcomes and on aspects with a financial focus, such as denials and management of length of stay. Although satisfaction among the pilot unit team members was not measured, there were requests from multiple other care teams for NCMs to be added to their teams.

Upon both financial and quality success of the NCM role and the triad model of care in the Cardiac Center, the original stakeholders met again to develop a plan to add more NCMs. Over the next 24 months, new NCMs were slowly introduced throughout the hospital. A graduated approach was beneficial in ensuring the small CM team could manage orienting newer team members while developing processes, metrics, and cohesiveness. Originally positioned as a unit-based role, newly added NCMs were initially assigned to nursing units. After implementation to medical and surgical floors, the group pivoted and changed assignments based on the provider team to allow for the NCM to participate and communicate in daily rounds with the care team. As each NCM was hired, the manager ensured an effective triad was formed: one NCM, one SW, and one UMN. There are now nine full-time NCMs employed at this hospital. The teams continue to evaluate processes, develop standard workflows where needed, and refine metrics.

Results

Justifying the NCM positions was a constant effort to quantify the improvements made and dollars saved and was accomplished through the capture of delays avoided through NCM interventions and the use of trackers to determine optimal caseload and tasks per role. The NCMs were able to provide an immediate cost–benefit to help justify their salaries. The NCMs are proficient in recognizing potential delays, questioning ways to mediate them, and then working within the team and across disciplines to eliminate them. Each of the NCMs kept trackers to record tasks, meetings, interactions, phone calls, and documentation. This list was then used to determine how long each of these tasks took to complete; who, if anyone had previously been completing the task; how frequently the tasks were encountered; and the rationale for the NCM performing the task. On the basis of this information, the team developed a "complexity score for discharges," listed in Table 3. The NCM role has most definitely impacted an overall improvement in length of stay, readiness for discharge, and patient/family service and satisfaction. Table 4 describes improvements led by NCMs, such as a change to the NCM obtaining medication prior authorization 1–2 days prior to discharge, and the development of a wheelchair and commode consignment process and standardization of medical service discharge orders. These interventions were developed as countermeasures to observable delays in discharges.

Limitations

The NCM role has been successful within the past 3 years throughout the children's hospital, but there is still a need for improvement in determining productivity. Using avoidable day reductions and decreased denials as two clear indications of success did not take into consideration barriers outside the NCM's sphere of influence. Continued work on the effective reporting of readmissions and efficient transitions of care is ongoing and will provide more robust information on success and areas for improvement with this role and model.

Implications for Case Management

Health care systems continue to be challenged to provide the highest quality of care within a limited financial system and penalized when length of stay or patient complications jeopardize the standard

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TABLE 3
Level of Complexity for Discharges

Level of Discharge	Time Investment	Examples
Level 1	Tasks can take 30–45 min/case	Screening for case management need requires a letter of medical necessity or a simple authorization
Level 2	Tasks can take 45–90 min/case	Discharges requiring two to three interventions, such as prior authorizations for medications, letter of medical necessity, and contacting existing services in the home with an update
Level 3	Tasks can take 1.5–6 hr/case	Procurement of home services, allocation of durable medical equipment, skilled nursing for the first time for a patient
Level 4	Tasks can take 6–32 hr/week/case	Most intensive discharge planning, such as those requiring home tracheostomy/ventilator, 24 hr of private duty nursing

expectations (Zazworsky & Bower, 2016). Creativity must be used to review and evaluate processes that work. In changing the model of discharge planning to incorporate NCMs to the existing utilization management–SW dyad, an enhanced team emerged, with each discipline practicing at its fullest capacity. In preparing for this team introduction and development, there is a lack of evidence to support any

TABLE 4
Nurse Case Manager-Led Interventions

Team	Prior Workflow	Interventions	Effects
NCM team	Provider orders discharge needs on day of discharge, sometimes creating delays due to needed authorizations, timely referrals to vendor, insufficient time for family education, and family choice	Creation of standard discharge order sets for postdischarge needs, such as feeding tube supplies, DME, and skilled nursing visits	Standard orders can be initiated by the NCM and then checked and signed by providers earlier in the hospitalization
			Orders are placed in a more timely way to allow for obtaining authorizations
NICU NCM	Reports on newborn screening were not always directed to the provider in a timely manner	The NICU NCM consistently became the point person on rounds who receives notification from the newborn screening team regarding need for referrals or repeat testing	The NICU NCM communicates information on rounds, ensuring timely countermeasures are completed
Orthopedic and ED NCMs	Wheelchairs and other equipment would be ordered on day of discharge—Lack of availability resulted in avoidable inpatient days	Creation of wheelchair, commode, and shower chair consignments in the hospital	Equipment is available to take home with the family
NCM team	Care teams had to call multiple vendors to find appropriate equipment, fax information to vendors, with no clear tracking to determine whether equipment was delivered	Obtained approval for NCMs to utilize online, web-based system for ordering DME if consignment not sufficient or the patient requires DME other than wheelchairs, commodes, and shower chairs	In utilizing an electronic system, approvals, need for further information, and delivery tracking are all visible via a phone app, allowing for greater transparency in the process
NCM team	Providers would obtain medication prior authorizations from insurers	NCMs took on this responsibility and also worked with providers to prescribe medications 2–3 days prior to discharge to allow time for insurer to approve the medications	Providers are freed up to attend to clinical issues at the bedside, medications are ready at the bedside prior to discharge, and there are less delays in obtaining medications by the family
NCM and UMN teams	UMNs would need to contact providers for clarifying questions and to request peer-to-peer reviews for denials	NCMs attend rounds and request further information as needed in the moment	Approximately 20% of peer-to-peer reviews were not completed by the child's provider—That has been reduced to <5%
		Peer-to-peer requests are now initiated by the NCMs	
NCM and SW teams	Confusion for how roles would be changed and defined	Continuous improvement RACI events held with teams as needed to define: responsibility, accountability, consulting, and informing roles	Individual team members are able to avoid duplication of efforts and have enhanced communication

Note. DME = durable medical equipment; ED = emergency department; NCM = nurse case manager; NICU = neonatal intensive care unit; SW = social worker; UMN = utilization management nurse.

Health care systems continue to be challenged to provide the highest quality of care within a limited financial system and penalized when length of stay or patient complications jeopardize the standard expectations.

specific guidelines, but there are resources to assist and guide teams in ensuring best practice as it relates to pediatric CM. Furthermore, standardization of practice is generalized. There remains a need for more robust information, studies, and benchmarking around effective CM in pediatrics.

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