IssueBrief
VOLUME 2, ISSUE 3

From "turf" to "team"

Case management interfaces with team-based care models

"Turf" is a four-letter word in today's changing health care landscape. Along with its sister term "silo," turf battles contribute to fragmented, inefficient care delivery. Health care organizations, and even health care workers within organizations, historically have operated as separate units, acting without the benefit of complete information about the patient's condition, history or care provided in other settings. Today's new models of care—the medical home, advanced primary care and accountable care organizations—are a stark contrast: collaborative and connected.

Moving from "turf" to "team" is a journey. A decade ago, the Institute of Medicine proposed a fundamental, sweeping redesign of the entire health system in a nationwide call to re-connect the pieces—to bridge what it dubbed the "Quality Chasm" and enable safe, effective, efficient, personalized, timely and equitable care.[1] A key tenet of this

Today's new models of care—the medical home, advanced primary care homes and accountable care organizations—are a stark contrast: collaborative and connected.

---

[1] The Institute of Medicine, Committee on Quality of Health Care In America. *Crossing the Quality Chasm.* Washington, D.C. National Academy Press. 2001.

"There was leadership and the opportunity to be funded for a high-level initiative that would transform the system."

—JOANNE M. SHEAR, MS, FNP-BC, NATIONAL CLINICAL PROGRAM MANAGER, PRIMARY CARE, VHA

redesigned system is the creation of patient-centered care teams.

The concept of the care team can be traced back to the work of Martin Cherkasky in the late 1940s at Montefiore Hospital in New York. Initially, health care teams—physicians, social workers and nurses—were a means to provide home care services to patients through a hospital outreach program. While the concept took hold in other countries that focused on a strong primary care concept, the interdisciplinary team model caught on in our nation primarily in community health centers as a means to provide centrally located benefits to the poor and underserved.

Over the years, the evidence mounted on the side of team-based care models to produce higher quality outcomes. Research indicates that better care coordination brought about by this approach leads to improved performance in chronic disease management, patient satisfaction and access to care.[2] Economically, team-based care makes sense as well: Better division of labor between the physician leader and lower cost personnel on the team can yield higher productivity and the ability to manage larger patient panels.

The Veterans Administration—Leading the Way

Fast-forward to 2009. After a decade of building a foundation in primary care, the Veterans Administration took a new step in its plan to redesign health care delivery. The Office of Patient Care Services, Primary Care Program Office, began a new initiative that year to implement a patient-centered medical home (PCMH) model at all Veterans Health Administration (VHA) primary care sites. Spearheaded by VA Secretary Eric K. Shinseki, the initiative came to be known as Patient Aligned Care Teams (PACT), and is characterized by providing accessible, coordinated, comprehensive, patient-centered care, managed by primary care providers with the active collaboration of other clinical and non-clinical staff.

"The VHA had been really looking at new models of care. We have had a well-established primary care system since the 1990s, but wanted to move it to the next phase," said Joanne M. Shear, MS, FNP-BC, National Clinical Program Manager, Primary Care, VHA. "There was leadership and the opportunity to be funded for a high-level initiative that would transform the system."

Redesign on a large scale: Electronic health records keep data on track

The VHA is the country's largest integrated health care system, serving some 5.6 million veterans through its 152 medical centers and approximately 700 primary care service sites across the country. Steering a ship that big took careful planning, and VHA leadership invited expert guidance.

"We built our model based on a lot of work," Shear said. "We consulted with Tom Bodenheimer, MD (of the California Healthcare Foundation), Geisinger Health System, Duke University, and the Patient-Centered Primary Care Collaborative. We visited tons of places and talked to people who were implementing the medical home—the American Academy of Family Physicians, American College of Physicians and others." In June 2009, VHA hosted a medical home state-of-the-art conference, using the venue and thought leaders to formulate a plan and build the structure for a sweeping new system for primary care delivery.

The workforce serving VHA health care is a small army in and of itself.

[2]Bodenheimer, Thomas. Building Teams in Primary Care: Lessons Learned. California Healthcare Foundation, July 2007.

Rather than attempting wholesale implementation of the new model, the program began with a relatively small development cadre. Eight national workgroups totaling about 200 individuals—from people on the front lines of care to major national thought leaders—developed the component parts to an overall strategic plan, plus the training curriculum to extend the model across the VHA system. The planning stage culminated in a Medical Home Summit in April 2010, involving some 3,500 attendees—most of whom were front line staff early adopters who would be trained to become the new Patient Aligned Care Team members.

Although that meeting officially launched the program, many sites had already advanced through planning and organization and were ready for implementation.

For instance, the core unit for PACT—the "teamlet"—was carefully researched and structured from the start to follow the model put forward by Bodenheimer[3] and based on many team-based models he observed in the field. Each of the VHA's teamlets is composed of a provider (a physician, nurse practitioner or physician assistant), plus a Registered Nurse, clinical associate (an LPN, LVN or sometimes a medical technician) and a clerical associate. Currently, there are some 7,000 teamlets in operation; each is assigned to a patient panel it manages. While panel sizes average 1,200 patients, the VHA's sophisticated database assigns each individual patient to a primary care provider and recommends panel capacity through a methodology that takes into account patient acuity, facility and practice size, and number of available support staff and exam rooms, so the numbers adjust accordingly. This ensures that teamlets, which are responsible for the health of the panel population, have adequate resources to manage the panel.

"If you pull up a patient chart anywhere in the VHA's electronic medical record system, the primary care provider's name assigned to that patient will appear at the top of the chart—and that's true for every provider in the VHA system across the country. You know who the patient is assigned to, and who has ultimate responsibility for the patient," Shear said.

The care coordination function: Integration with the role of the professional case manager

Within each teamlet, the RN serves in the care management role. "That role is critical as far as making sure critical transitions of care take place, since a lot of our patients see specialists outside the VHA," Shear said. The RNs perform population health management and medication reconciliation, and keep a careful eye on the frail elderly and patients who are frequently admitted to facilities. "Their role is essential," she said. "A lot of our time in training the team is spent really defining how critical that role is."

Primary Care in the Veterans Health Administration

- Largest integrated health care system in the U.S.
- Comprehensive electronic medical record
- 850 sites of primary care
  - 152 medical centers
  - >700 community-based outpatient clinics
- 5.6 million primary care patients—each assigned to an individual primary care provider
  - 53% in community-based outpatient clinics
- >12 million encounters/year

[3] Ibid.

The VHA has long been an advocate of case management to support its specialty care units, employing thousands of case managers across its system in areas such as behavioral health, spinal cord injury, gynecology, oncology, diabetes care and transplant surgery. "The case manager can be a social worker or an RN, and it's usually someone with a specific disease focus," she said.

Integration of case management with the teamlets is important for these special cases. The PACT model calls for the RN care manager to interface with the case manager for resources outside those the team usually needs to access.

"For example, if one of my patients was being treated for an oncological condition, many times those specialists take over the patient care during the treatment period. The oncology case manager would then become involved with the RN care manager on the patient's primary care teamlet, to make sure the patient is getting the regular care they need plus any care from the oncology team. It really is a matter of gathering the resources you need to make sure you're managing all the patient's needs."

Under PACT, these interfaces are becoming smoother because the teamlet is ultimately accountable for the majority of coordination, "and they need to be the party to track and maintain the interactions across care settings," Shear said.

"The idea is, it's not just that we're turfing the patient to oncology. It's more that we're collaborating with oncology on behalf of the patient. That's part of the infrastructure we've built."

VA recognizes value of CCM®

The Commission for Case Manager Certification's prestigious board-certified CCM® designation is now within closer reach for thousands of professionals who have served in the military or reserves, as well as their dependents. Payment for CCMC's certification exam has been approved by the U.S. Department of Veterans Affairs (VA) as reimbursable under the GI Bill for licensing and certification.

The VA's approval of the CCM certification exam means that veterans, reservists and their dependents who are case managers are eligible for reimbursement for the cost of the exam under the GI Bill, a $325 value. The CCM is available to case managers who serve in a variety of settings such as hospitals, managed care organizations and in independent practice, and with a range of professional licensure, including nursing, social work and vocational rehabilitation. More information about VA reimbursement of the CCM credential is available by going to the Commission's website, www.ccmcertification.org.

Making the team interface with case management within the VHA

From her perspective, the professional case manager is the "conduit for the patient," said Kathryn M. Serbin, BSN, MS, CCM, section chief of the Women's Health Clinic and senior nurse, surgical clinics at the Ambulatory Care Center of the James A. Lovell Federal Healthcare Facility in Chicago, a VHA-system facility. Serbin also serves as chair-elect of the Commission's board of directors.

Since January 2011, Serbin has been instrumental in developing an interdisciplinary team model of practice which combines OB/GYN specialty care, a women's wellness primary care teamlet and other specialty services, whose focus is patient-centered care that efficiently implements the model with effective use of case management. In the Women's Health clinic, one of the two case managers is embedded within the primary care teamlet and takes part in interdisciplinary team meetings and daily huddles, and participates in meetings with the client. The case manager is encouraged to interact with other disciplines within the facility to more quickly make resources available to clients as well.

Serbin said that, while the primary care case manager has long played a supporting role in the

"It's the responsibility of the professional case manager to show the value added when they are part of the team, so they see you as a colleague. It is the responsibility of the clinic leadership to ensure that the team understands the differing roles and relationships to promote the development and achievement of a high-functioning team."

—KATHRYN M. SERBIN, BSN, MS, CCM, SECTION CHIEF, WOMEN'S HEALTH CLINIC AND SENIOR NURSE, SURGICAL CLINICS AMBULATORY CARE CENTER

practice, that role hasn't always been appropriately defined.

"Now that her role has been redefined, she is seeing a positive response from the patients," she said. "Professional case managers have an important part to play in informing the team about the client's needs because of their dynamic relationship with them. They help to clarify the client's barriers to the team, barriers that the patient may not express to the primary care provider or even the RN. The patient is the puzzle, and the professional case manager pulls all the information pieces together to give the full picture of the client to the team."

Educating the client is one aspect of the professional case manager's work, but the case manager also educates others about the client, Serbin said. "Our case managers educate the team about what resources are available and provide information about evidence-based practices and resources in the community. They engage the team in dialogue about the client. That's a very important role, because otherwise care can be fragmented. The primary care provider really doesn't have the time to engage a complex patient in that kind of dialogue."

Serbin has seen her case managers engage directly with clients to bridge communication gaps. "I just recently saw this with one of our clients. She's a very complex patient, and the case manager has been able to enlighten the team about some of the barriers she has to getting health care. Often, the client may leave the exam room and not understand what she's been told because there is a health literacy issue, or a family barrier to getting care or follow-through on the plan of care. The case manager helps bring this to light, and helps keep the focus on the client."

Important to this successful interface was carefully defining the case manager's role. "Before, they were using the case manager to do administrative tasks, like surgical scheduling and patient appointments, and she wasn't able to function as a case manager," she said.

Serbin said time was well spent educating the different members of the team about the role of the case manager and what she could bring to the table. "Oftentimes as a case manager, when you're put into a primary care team you have to readjust. You're no longer just independently picking up a phone and talking to a client directly; you have to work together. Many times, you are working with the other members of the team to build the relationship. It's face-to-face dialogue with the team, and on a daily basis."

Sharing the turf and becoming part of the team

Team-based integration requires a servant-leader approach, Shear said. "It's saying, 'this is where the patient may need help, these are the resources I can garner, so let's work together.' It's a collegial model, versus a 'he's mine/he's yours' kind of thing," she said. "That takes a special skill set. Not that it can't be learned, but it's not easy to do."

Turfism is a problem best solved by role clarification, she said. "It really is all about turf—what I think you should be doing, and what I think I

Training centers on the team

Training for team-based care delivery has long been a challenge in health care. Traditional health professional education emphasizes separate, specialized training and doesn't prepare participants to work together, form teams or share responsibilities. Collaborative education—bringing team members together to engage in learning with, from and about each other—is built on the principles of cooperation and coordination between members of the team.[4] For its PACT initiative, VHA leadership carefully planned a three-pronged approach.

- The first major training component is the PACT Collaborative, carried out in five regions across the country and involving about 1,300 people in 250 teams. The teams are intensively trained in an experiential learning model borrowed from the Institute for Healthcare Improvement. The teams are trained as a unit in six week-long learning sessions over the course of 18 months.

  "Each learning session is based on the team, and much of it is team talk time where they plan and strategize, and have interaction between the groups," Shear said. "They start from knowing nothing about the medical home to where they're really doing a great job. This model is also helping us to develop our overall training curriculum." Leadership of the PACT Collaborative is managed by a national steering committee. The first wave is nearly through the six-phase process. These early adopters return to their practice sites as leaders, training others and standing up other teams.

- Five Learning Centers of Excellence are also training teamlets in team-based care. These regional virtual learning centers provide a "medical home 101 coach" to train personnel over a three-day period, and practice sites must follow a collaborative model—the entire teamlet has to participate in training together.

  "Each year we're expected to train 1,250 teams across the country through the Learning Centers of Excellence," Shear said. "We are meeting and will probably exceed this goal this year. It's like a mushroom effect. You have a virtual learning session, then you have a virtual faculty that you train. Every site uses the same content, and we just train the faculty. Those are managed by the five virtual centers."

- The third training prong is structured through five consultation teams, each composed of a nurse, a physician and administrator. These teams are designed to evaluate challenges to and issues with implementation using a facilitative approach. Team consultations are initiated by medical center directors, and are designed to be collaborative. "The issues may be around engaging leadership, team dynamics, clarifying roles or engaging unions," Shear said. Planning calls precede consultation visits, so the approach is well defined for all participants and issues are addressed without finger-pointing.

[4] Brian Schuetz, Erin Mann and Wendy Everett. Educating Health Professionals Collaboratively For Team-Based Primary Care. *Health Affairs,* 29, no.8 (2010):1476-1480. Accessed 5.23.2011 at http://content.healthaffairs.org/content/29/8/1476.full.html.

should be doing. The team is about letting go and trusting, knowing you're accountable, but also giving the authority so others can go ahead and manage patient care based on their expertise. That's not always easy, even for a team, to allow." Shear offered words of advice to professional case managers working to interface with team-based models of care.

"First, know that you're not alone. It seems that in the past, case

managers thought they didn't have anywhere to go, especially if they were working in a specialty population. Knowing that they can work with a team of people who are assigned the overall care of the patient really helps.

"Also, know that you have an integral role to play," she added. "Primary care can't do it all, and we're not the experts beyond the scope of primary care. In all the studies we reviewed and read, we found that case managers are critical to the success of this medical home concept. They are the linchpin, they're the folks that, when push comes to shove, have to help the patient work through the issues."

Serbin again emphasized how important it is to carefully define the role of case manager in the context of the primary care team.

"It has to be about building relationships," she said. "It's the responsibility of the professional case manager to show the value added when they are part of the team, so they see you as a colleague. It is the responsibility of the clinic leadership to ensure that the team understands the differing roles and relationships to promote the development and achievement of a high-functioning team." It is important for the team to be provided the opportunity to dialogue about the integration of case management into a care system; it often involves a paradigm shift and a realignment of roles and responsibilities that may take time to accomplish. Emphasis on "health care" rather than just "medical care" broadens the roles and responsibilities of all team members.

Serbin said it is also important to engage leadership for support. "If you don't have support, you will end up doing myriad things that are not related to case management. We had to develop our professional case manager's role because her caseload had to grow, and from the team's point of view it didn't look like she had much to do in the beginning." Case managers are able to achieve effective and efficient outcomes if their skills are successfully targeted to at-risk clients.

For those moving to new case management positions with a team interface, Serbin strongly recommended asking for a clear-cut position description from the start. "Negotiate early on if you don't think it's accurate or if it's something not within the practice of case management," she cautioned. Loosely defined roles such as "patient navigator" and "care coordinator" tend to muddy the waters. "It's important early on for the case manager to have a voice in how that role is implemented," she said.

Along with the need for qualified RN care managers, Shear said the need for case managers continues to be huge, given the shortages in primary care. "The case manager is the catcher's glove, the coach and the mentor. I see that as a critical role and see it growing and growing."

Serbin added that board-certified case managers have the credential that demonstrates more than just competence, but peer-recognized capabilities in the team-based environment.

"The case manager is the catcher's glove, the coach and the mentor. I see that as a critical role and see it growing and growing."

—JOANNE M. SHEAR, MS, FNP-BC, NATIONAL CLINICAL PROGRAM MANAGER, PRIMARY CARE, VHA

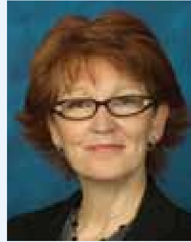
"Certification means credibility, and ours (the CCM®) is the gold standard," she said. "We don't limit certification to practice in a hospital setting or any other specific environment. The Commission—and our certification program—recognizes that case management occurs in many different health care settings. It's rooted in evidence-based practice. We have embraced that for years through the exam, and now through the Case Management Body of Knowledge™." The Commission's Case Management Body of Knowledge (CMBOK™) is the first comprehensive, Web-based, peer-reviewed, online knowledge resource available for professional case managers.

About the Experts

Kathryn M. Serbin, BSN, MS, CCM
Section Chief, Women's Health Clinic and Senior Nurse, Surgical Clinics Ambulatory Care Center of the James A. Lovell Federal Healthcare Facility;
Chair-elect, Commission for Case Manager Certification

Serbin, who holds the Navy rank of captain, served on active duty as division officer for inpatient mental health and later as special assistant to the commanding officer of Naval Hospital Great Lakes. In the reserves since 1995, she served as training officer, clinical coordinator, officer in charge of a detachment and then officer in charge for reserve corpsmen and instructor training at Naval Hospital Corps School. In 2006, Serbin was deployed to Landstuhl Regional Medical Center (LRMC), Germany as part of a contingent of Navy personnel (active and reserve) from 10 Operational Health Support Units, the first Navy contingent to provide support to LRMC. Serbin served in the Behavioral Health Directorate at LRMC and instituted the first inpatient case management program there. In 2009, she was appointed by the Navy Surgeon General as the mental health specialty leader for reserve corps nursing.

Serbin is the recipient of numerous awards and commendations for meritorious service and is a member of the Village of Streamwood Veterans' Commission. She holds a master's degree in psychiatric nursing and is a board-certified case manager.



Joanne M. Shear, MS, FNP-BC
VACO Primary Care Clinical Program Manager, Office of Primary Care Services Veterans Healthcare Administration

Shear is a consultant to key management officials regarding the collection and analysis of system-wide health care data and trends. This includes consulting on the integration of measures and models for assessing health care trends, care delivery systems, quality, risk and utilization of resources throughout the nation. She holds a bachelor's degree in nursing from Russell Sage College in Troy, NY; a master's degree in nursing administration from State University of New York, Utica; and a nurse practitioner certificate from Russell Sage College.

To learn more about the role and function of the professional or board-certified case manager in new models of care, read the issue brief, "Care Coordination: Case managers 'connect the dots' in new delivery models," at www.ccmcertification.org.

To learn more about the CMBody of Knowledge go to www.cmbodyofknowledge.com.

Commission for Case Manager Certification
15000 Commerce Parkway, Suite C ■ Mount Laurel, NJ 08054 ■ (856) 380-6836
www.ccmcertification.org

WRITTEN AND PRODUCED BY HEALTH2 RESOURCES. COPYRIGHT © 2011, CCMC