Redesign, align, communicate: Lessons from Geisinger’s case management system-wide transformation

For all the changes we’ve witnessed in health care delivery, health care is still typically sickness care, focused on the immediate presenting problem, the episode, the diagnosis. Even case managers, trained to take the long view, succumb to the tyranny of the urgent.

“What we know, however, is that as case managers, we must constantly move the focus back to the big picture: to transitions of care across the continuum, to alignment of the different pieces of health care,” says Patrice Sminkey, CEO of the Commission for Case Manager Certification. “No matter how much we accomplish, we must keep moving forward.”

Case in point: Geisinger Health System which, over the past 10 years, has refused to rest on its laurels and, working with case managers, has continued to reinvent itself.

In 2006, Geisinger Health System launched ProvenHealth Navigator®, which includes the case manager as a core member within the care team. It has become a model for similar programs around the country.¹

¹ A collection of studies and papers on the program is available at https://www.pcpcc.org/initiative/geisinger-health-system-patient-centered-medical-home-provenhealth-navigator

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— PATRICE SMINKEY, CEO OF THE COMMISSION FOR CASE MANAGER CERTIFICATION
This was just the first step in Geisinger’s ongoing redesign of its case management program. In 2015, Geisinger started the redesign of the inpatient and emergency case management departments. In September 2016, it began the development of a new approach to coordinating services in the ICU, and the goal is to enroll its first patients under the new model by the end of October.

Inpatient case management: Connecting the pieces

Redesigning inpatient case management was less about creating a new program than about aligning existing ones.

"Many of our hospitals had inpatient case management for decades," explains Janet Tomcavage, RN, MSN, chief population health officer, Geisinger Health System. "The task was to reconfigure hospital case management team roles and develop ways to more closely align with the ambulatory case management team to support effective transitions of care."

The first step was to bring both the ambulatory and the inpatient teams under the same leadership umbrella. The second was to develop a new vision. "We came up with our own Triple Aim within case management with transitions as a critical core focus."

Appropriate length of stay:

“We try to effectively manage the patient’s journey and anticipate the next phase of treatment. We prepare patients for what’s coming next.” What’s significant about this approach, she says, is that it seeks to optimize the length of stay. "Most hospital-based programs are very focused on shortening the stay. Our intent is to manage to the ‘right’ length. That might mean we let the patient stay a day longer to get more rehab; that could mean we send the patient home instead of to another inpatient facility for continued rehab.” Optimizing length of stay means keeping the patient at the hospital if that’s what’s needed to reduce the risk of readmission, she says.

She expects more health care organizations to follow Geisinger’s example and work toward optimized, rather than shorter, lengths of stay as value-based reimbursement gains ground. It makes sense to focus on value and quality: The evidence shows that high-quality hospitals have lower readmission rates than lower-quality ones, and that translates into savings.²

Readmission prevention:

“When you asked our case managers what role they had in readmission prevention, they weren’t always sure,” she says. So part of the redesign is to get them to think critically about what sorts of things could get patients in trouble once they leave the acute care environment. Those could include lack of social supports; finances; safety in the home; dehydration; infection; fluid overload;

² Tsai TC, Greaves F, Zheng J, Orav EJ, Zinner MJ, Jha AK. Better Patient Care At High-Quality Hospitals May Save Medicare Money And Bolster Episode-Based Payment Models. Health Aff (Millwood). 2016 Sep 1;35(9):1681-9 content.healthaffairs.org/content/35/9/1681.full
medications; limited patient/family/caregiver understanding of how to manage the condition; pain management and more. Often, she says, the patient knows the answer; the case manager merely has to ask.

**Discharge disposition optimization:** “Our goal is home first: What will it take to get the patient home safely?” Sometimes, patients are discharged to a skilled nursing facility because, she says, “it’s the easiest lever to pull.” It’s a difficult conversation for inpatient care teams to have, but it’s a necessary one. She acknowledges that patients can’t always go home—perhaps due to the complexity of their condition or because social factors don’t support it. The question then becomes, “What is the best next level of care in terms of optimal outcome?”

The common theme in all three is identifying the optimal patient and family experience. “If we do all three things well every time, this will drive positive patient and family experience for the people we serve and we can achieve the Triple Aim.” That doesn’t mean it’s as easy as 1-2-3: Aligning the inpatient and ambulatory programs proved challenging, and it’s still a work in progress, she says.

**New inpatient roles**

Before the redesign, the inpatient case management teams included an RN case manager, a licensed social worker and a care management assistant. Those roles remain, although some teams need to redefine the roles of the RN case manager and the licensed social worker.

“Those roles have blended over the years. Sometimes, the nurse takes the right side of the hallway and the social worker takes the left. I’m not sure that best aligns the skill sets. We’re looking carefully at how we can think differently about the team and how to align with patient needs,” says Tomcavage.

Two new members will be joining the inpatient teams:

**A health liaison:** Generally an RN case manager, the health liaison meets with patients in the hospital to help optimize the next level of care placement: If the patient goes to a post-acute care facility after discharge, the health liaison follows. The liaison helps manage length of stay and discharge preparedness, and connects with the ambulatory case management team.

**A specialist case manager:** Depending on the population, Geisinger will add a specialist case manager to some teams, just as it has on the ambulatory side. For the most part, she explains, Geisinger uses a generalist case manager model, but by watching trends, she and her team can identify populations that may benefit from a specialist case manager. Among the specialties for which there’s an identified need are emergency medicine, cardiology, nephrology, orthopedics and pulmonary medicine.

**Getting there from here**

Tomcavage offers advice—advice based on some hard lessons—to those interested in following Geisinger’s example and designing or revamping case management teams.

1. **Don’t wait for perfect.** You will wait forever. “Small tests of change work. You can start with a subpopulation and move from there.” When Geisinger launched ProvenHealth Navigator in 2006, it started with high-risk Medicare patients and then expanded. She suggests narrowing it

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down even more—perhaps targeting only heart failure and COPD. “Start somewhere you can show an impact.” And what shows an impact, she says, are transitions of care. “Transitions of care can give you the earliest win.”

2. **Be willing to move on.**
   “Case managers need to give patients up.” Some patients are very complex, and case managers may need to find different ways to manage them.“But with others, you need to cut the apron strings. You’ve brought them along, helped them through the acute care episode, prepared them for the next stage,” she says. Yes, it can be difficult to let go. “We thought patients would come to us and stay forever. But that’s not how you make your biggest impact.”

3. **Demonstrate your value to the providers.** You need leadership support to initially “clear the way,” she says. But after that, it’s about showing value to the clinicians. “In the end, no amount of marketing for your case management service will work. You need to show outcomes, one patient at a time. Show something had some impact on a patient. That will be the best marketing tool.” And that, in turn, will help improve outcomes even more. The more closely aligned the case manager is with the provider, the greater the impact on patients.

4. **Communicate clearly.** For Geisinger, the biggest challenge to aligning inpatient and ambulatory care case management teams was time. Neither side believed they had time to call a colleague on the other team. It was also difficult to be succinct when those calls were made. To address that, Tomcavage encouraged them to focus on one issue: “What does the other team need to know to take better care of the patient they are getting? That’s been the win for our integration.”

5. **Train and mentor.** “I cannot say enough about the training infrastructure you need. It can take a year or more before case managers really know what they are doing. This is not an easy job.” It requires supervision, education and mentoring. “I wish I could find already trained case managers.” To that end, she believes in certification. It’s not required for hire, but case managers need to achieve certification within two years. “We support it. We pay for it. It’s worth the investment.”

Geisinger continues to be held up as a model of integrated health care, and its case management program is recognized around the world. But even so, it’s imperfect and probably always will be. “It’s a journey. We have work to do, and it’s far from over.”

And that, says Sminkey, may be the most important lesson of all. Providing successful case management is not a “once and done” effort.

“Case managers can influence the simultaneous improvement envisioned by the Triple Aim framework,” she says. That may mean stepping out of one’s comfort zone and becoming proactive—on strategy and planning teams, or even evaluating metrics that involve shared responsibility for reducing readmissions or cost per case.
There’s always room for improvement. Sminkey points to one other recent change at Geisinger to illustrate this.

Rethinking population health

Until the last year or so, Geisinger focused on the “sweet spot” for case management: patients with Geisinger Health Plan (GHP) insurance. It made sense, given that 26.2 percent of Geisinger Health System patients were GHP members, and 32.5 percent of GHP members saw a Geisinger Health System primary care provider.

But by January 2016, it had abandoned its “sweet spot” and moved to a “One Geisinger” approach. “We are managing all patients and members that Geisinger serves with one approach,” Tomcavage explains. The rationale is simple, but it represents a dramatic change in how the organization understood the “population” in population management. “To impact a population, we need to manage the whole population.”

“You can’t overestimate the importance of that decision,” says Sminkey. “Population health is a critical part of the big picture—and it’s the one most likely to be overlooked.” The Institute for Healthcare Improvement introduced the Triple Aim framework in 2007 as a simultaneous focus on improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. But too often, “simultaneous” is more aspiration than reality, she says.

“What’s exciting about what’s happening at Geisinger and elsewhere is that organizations understand the importance of that ‘middle child,’ population health. And they’re developing new strategies and tactics to ensure the health of populations.

“As case managers, our focus tends to linger on that first point of the Triple Aim, the patient experience of care. And the nature of today’s health care system—with the move to integrated systems and bundled payments—increasingly pulls our attention to the third point in the framework: lowering costs.” As a result, population health often gets overlooked.

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This article features interview content from the late CEO of the Commission, Patrice Sminkey, who died unexpectedly on Sept. 22, 2016. Her legacy lives on in the Commission’s commitment to advance the case management practice.
Patrice Sminkey, Chief Executive Officer, Commission for Case Manager Certification

Sminkey came to the Commission from URAC, where she served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brought a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. Her experience included client management, coordination and retention and business expansion.

In her six years as CEO of the Commission, Sminkey led the organization to a fiscally sound and operationally advanced position. Her efforts behind the scenes made the organization more agile and responsive to board-certified case managers and certification candidates. She guided development and launch of a suite of education and professional development tools to support an informed, relevant and expanding case manager workforce, including the CCMC Case Management Body of Knowledge®, online learning tool, the CMLearning Network® and the CCMC New World Symposium.

Sminkey worked closely with and enjoyed a productive, positive relationship with the Commission’s board and many volunteers, leading through example with her personal commitment to advancing the practice of professional case management.

Janet Tomcavage, RN, MSN, Chief Population Health Officer, Geisinger Health System

Tomcavage is responsible for strategy development and oversight for Geisinger’s system-wide value based re-engineering initiatives. This includes population health management functions for Geisinger Health Plans including ProvenHealth Navigator® (Geisinger’s advanced medical home), disease and case management, wellness, medical management, clinical informatics, and population health information systems development. Tomcavage also served as the chief population health officer at xG Health Solutions™, an independently operated venture making Geisinger’s intellectual property and expertise available to other health care systems.

Tomcavage earned her bachelor degree from Bloomsburg State University and her master’s degree from College Misericordia. She has co-authored publications on patient-centered primary care, diabetes, disease management and the expanded role of nursing in health care. Tomcavage has lectured nationally on successfully driving transformation within health care and leveraging population health to achieve high quality and affordable health care.

Tomcavage was the first nurse at Geisinger to win the Pennsylvania Nightingale Award for clinical excellence in an advanced nursing role. She is an active member of the American Nurse Association, the American College of Healthcare Executives, the Alliance of Community Health Plans, and the PA Chronic Care Collaborative.