



COLLABORATE[®]: A Universal Competency-Based Paradigm for Professional Case Management, Part III: Key Considerations for Making the Paradigm Shift

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ABSTRACT

Purpose/Objectives: The purpose of the third of this 3-article series is to provide context and justification for a new paradigm of case management built upon a value-driven foundation that

- improves the patient's experience of health care delivery,
- provides consistency in approach applicable across health care populations, and
- optimizes the potential for return on investment.

Primary Practice Setting(s): Applicable to all health care sectors where case management is practiced.

Findings/Conclusions: In moving forward the one fact that rings true is there will be constant change in our industry. As the health care terrain shifts and new influences continually surface, there will be consequences for case management practice. These impacts require nimble clinical professionals in possession of recognized and firmly established competencies. They must be agile to frame (and reframe) their professional practice to facilitate the best possible outcomes for their patients. Case managers can choose to be Gumby or Pokey. This is exactly why the definition of a competency-based case management model's time has come, one sufficiently fluid to fit into any setting of care.

Implications for Case Management Practice: The practice of case management transcends the vast array of representative professional disciplines and educational levels. A majority of current models are driven by business priorities rather than the competencies critical to successful practice and quality patient outcomes. This results in a fragmented professional case management identity. While there is inherent value in what each discipline brings to the table, this advanced model unifies behind case management's unique, strengths-based identity instead of continuing to align within traditional divisions (e.g., discipline, work setting, population served). This model fosters case management's expanding career advancement opportunities, including a reflective clinical ladder.

Key words: case management, competency, health care, nursing, model, paradigm, social work, transdisciplinary

In the months since COLLABORATE[®] Parts I and II were published, we received spirited feedback about the model from the professional community. Themes have included but are not limited to the Paradigm's:

- Implementation potential across practice settings, with particular use for ambulatory care and community-based programs.
- Value to human resources with application to hiring and performance appraisals.
- Clear focus on performance metrics as outcomes.
- Worth as an integral tool to measure and validate overall case management returns on investment.

- Framing that recognizes the value of competency-based performance in a highly competitive health care environment.

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TABLE 1
The COLLABORATE® Competencies

Acronym	Competency	Key Elements
C	Critical thinking	Out of the box creativity Analytical Methodical approach
O	Outcome-driven	Patient outcomes Strategic goal-setting Evidence-based practice
L	Life-long learning	Valuing: Academia and advanced degrees Professional development Evolution of knowledge requirements for new and emerging trends (e.g., technology, innovation, reimbursement) Practicing at top of licensure and/or certification Acknowledging no one case manager can and does know all
L	Leadership	Professional identity Self-awareness Professional communication Team coordinator
A	Advocacy	Patient Family Professional
B	Big picture orientation	Biopsychosocial-spiritual assessment Macro (policy) impact on micro (individual) intervention
O	Organized	Efficient Effective
R	Resource awareness	Utilization management Condition/population-specific Management of expectations per setting
A	Anticipatory	Forward thinking Proactive vs reactive practice Self-directed
T	Transdisciplinary	Transcending Professional disciplines Across teams Across the continuum
E	Ethical-legal	Licensure Certification Administrative standards Organizational policies and procedures Ethical codes of conduct

Note. Copyright, T. M. Treiger and E. Fink-Samnack (2012).

We are inspired by industry recognition of the positive impact that a competency-based model, such as COLLABORATE®, poses for professional case management's future. As we noted at the conclusion of Part II, quality improvement implementation of COLLABORATE® requires top-down organizational alignment in combination with the full commitment of every stakeholder involved in the effort. Toward the purpose of engaging in this mindset, the goals of this article are to:

1. Discuss performance management implications that must be addressed as part of operationalizing COLLABORATE®.
2. Raise awareness of likely organizational obstacles to change.
3. Review barriers to change within the case management industry.

Part I of COLLABORATE® provided a historical retrospective to validate the model's foundation, including a general presentation of the included competencies (Treiger & Fink-Samnack, 2013a, p. 133). Part II focused on expanding the explanation of each competency (Treiger & Fink-Samnack, 2013b). To avoid repetition within Part III, please review these articles. Table 1 has appeared in Parts I and II of the COLLABORATE® series. This visual, which highlights each competency and its respective key elements, is included herein for ease of reference.

As you engage in Part III, we would like to make a suggestion. Those who contend that they are more a Pokey than a Gumby should begin to limber up now. Having defined performance expectations inevitably leads to flexing and bending in directions you may not have thought possible (Treiger & Fink-Samnack, 2013b). It is Time to Prime your Pump for Making the Paradigm Shift®.

CONSIDERATIONS FOR MAKING THE PARADIGM SHIFT

Change is the law of life and those who look only to the past or present are certain to miss the future.

—John F. Kennedy

Perhaps you are thinking, "How do I know if a paradigm shift is needed?" Consider the questions posed in Figure 1 when deciding if it is time to propose an organizational change of this magnitude.

While prior generations of case managers might have entered their first day of employment hoping for long-term career stability, a different reality emerged over the past several decades. The health care environment has been fraught with continuous change. Steadiness and status quo quickly became regarded as stagnation. In fact, how many organizations in the 21st century

You might need a paradigm shift if...

- Your organization has not had change in its Board of Directors in the last 10 years.
- There is no case management representation in the C-suite.
- The Case Management department reports within the Finance Department.
- When you ask if there is tuition reimbursement benefit your supervisor responds "Why do you need that?"
- Case management is referred to as Discharge Planning.
- There are separate departments for Utilization Review, Discharge Planning and Social Work Services.
- There is a revolving door for the Director of Case Management job.
- You introduce yourself to patients "Hi. I am Karen a case manager and my job is to get you out of the hospital and to get the hospital paid."
- Your organization's idea of Case Management is having you call members and spend hours interrogating them using a list of questions.
- You think the case management process is your organization's information technology system.
- Your organization's qualification for case manager positions allows LPN or LVN.
- When you ask if there is a bonus for obtaining certification your supervisor responds "Why would you need that?"

FIGURE 1

You might need a Paradigm Shift if

have you seen promote their constancy as opposed to status quo? (Cameron & Quinn, 2011, p. 1).

The shift in health care's business culture framing of the 1980s into the 1990s saw increased competition. This was fueled in part by expansion of medical knowledge from biomedical research and manifesting technology yielding expanded care options and longer lives for health care consumers (Fink-Samnick, 2008, p. 338). In tandem, a tidal wave of mergers and acquisitions (M & A's) occurred as free-standing hospitals consolidated and/or became part of larger systems, some forming care continuums. There were 310 M&As at the height of these actions in 1997 (Cuellar & Gertler, 2003). Those of us employed in the health care industry during these years endured significant occupational fluctuations as a result of these events. For some individuals working in case management, this translated to simultaneously managing their own changing titles, jobs, roles, and functions along with expanding clients, members, and benefit plan structures, often with little or no warning or training for taking on new responsibilities. However, case managers adapted to ensure both their own employment and the delivery of health care.

Fast forward to the present and the influence of advancing information technology (e.g., electronic health records, case management software, the use of personal computers, and the Internet), health care

reform legislation, and delivery models innovation (e.g., Accountable Care, Patient-centered Medical Homes, transition of care initiatives). The result is an interweaving of intricate fabric that wraps around every care setting like a Christo installation (Christo and Jean Claude, 2013). Suffice to say, change is a constant across the health care continuum.

URGENCY FOR A UNIFYING MODEL

The world hates change, yet it is the only thing that has brought progress.

—Charles Kettering

In addition to the historical grounding provided in Part I, the urgency for adopting a practice model that may be applied across the care continuum benefits from a few more points of reference. The Affordable Care Act took aim at many targets to open up access, lower cost, and improve quality of health care across the nation. However, during the same time period as numerous efforts to implement improvements in care delivery met with variable success (and resistance), spending for health care increased from 13% to almost 19% of Gross Domestic Product (Hernandez & Shewchuk, 2011, p. 253). Ironically, diminished performance on many indicators of health system efficiency, declining population health metrics, and more pronounced health disparities have been observed despite these dramatic spending increases (Commonwealth Fund, 2011, p. 15). Other considerations that occur at the levels of health care system, legislation/regulation, employer/organization, and individual are identified in Figure 2.

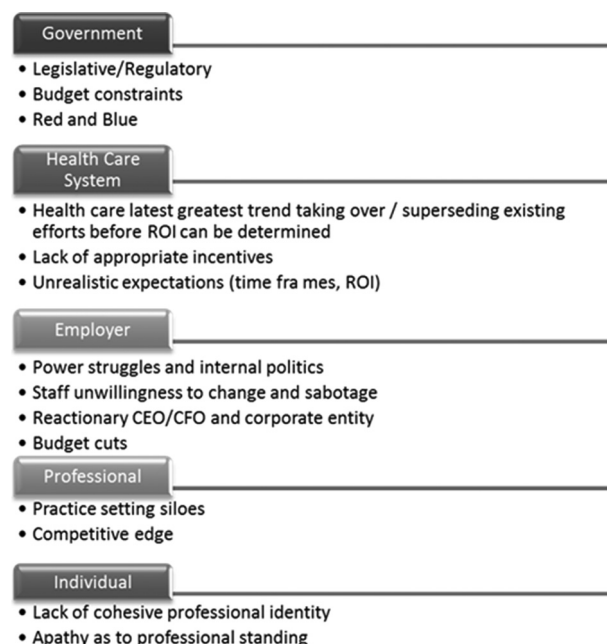


FIGURE 2

Influencers on health care diminished performance.

As the use of checklists providing specific intervention activities expands, so does the risk of overlooking vital information that may not be collected by these efficiency-focused tools.

Case managers have a key role to play in managing change of our professional development and work settings if these efforts are to ultimately result in care that is more consumer-centric and continuity-conscious. However, we must first address our individual and collective shortcomings to push the needle in a direction of positive growth. A consistent model of practice that de-emphasizes setting of care and focuses on personal accountability to specific behaviors and skills takes a giant step forward in that direction.

The lack of professional unity is ultimately concerning. Over recent decades, case management has failed to coalesce in a manner that demonstrates the likelihood of lasting cohesion. As a result, case management is not generally considered to be an organized force within health care. While some of this may be related to the disjointed nature of the U.S. health care system, many professional disciplines in the health and human services sector have managed to develop both umbrella entities and numerous specialty practice groups without it being seen as divisive; this includes, but is not limited to, medicine, nursing, social work, and so forth. Why does case management not follow this same path for professional advancement and sustainability?

There is also the point that case management developed as a dependent rather than a parent figure. In other words, case managers are generally task-oriented employees within large organizations rather than employers or contractors of their own services. This seems to be significantly impacting the ability to see case management develop beyond current limitations enforced by legislation, regulation, or organizational policy and procedure.

The collective “we” have failed to communicate and cooperate across the various stakeholder entities that represent case/care management practice. In a desire to emphasize the uniqueness of a given setting of practice or population, additional professional, accreditation, and certification bodies were established. This ultimately divides our numbers and results in far less powerful political clout. At times stakeholders appear to be working at odds with each other, while contributing to what presents as Case Management Identity Disorder (Treiger & Fink-Samnick, 2013a, p. 129).

General confusion as to the differences and distinctions between professional organizations, certi-

fication entities, and commercial enterprises continues. There has not been a lasting concerted effort to address this confusion, perhaps because it may be viewed as beneficial to maintain the lack of clarity? Rather than leaving the issue unaddressed, a more constructive approach is to collaboratively develop a professional career path that includes involvement in professional development activities, continuing education, and subsequent certification.

When we overlay case management industry-specific issues onto systemwide obstacles, it is a testament to dogged determination that case management still exists. However, in the absence of recognizing and acting upon the deleterious impact of these multiple factors, quasi-case management roles continue to proliferate within the industry. At this point in time, no single entity appears to have the support of the rank-and-file case management majority. These issues should be considered as priorities to industry stakeholders. The clock is ticking and dumb luck may run short if there is not a call (issued and heeded) for concerted professional advocacy, a competency integral to all case managers. In this way, the workforce may strive to address the issues over which our industry is accountable, by taking prompt action.

RESISTANCE + CHANGE = GROWTH

The greatest danger in times of turbulence is not the turbulence—it is to act with yesterday's logic.

—Peter Drucker

It is important to be cognizant of the reasons why change in a health care-related field has been so problematic. Simply put, it is difficult to push a rope and the U.S. health care system has proven to be especially rope-like due to special interests associated with politics, economics, and public perception. Blank (2012) summarized this issue well, “Forces in opposition [to change] include politicians who overpromise; drug companies, big medicine and a medical research community whose lifeblood is continual expansion of profit-making medical technologies; physicians who will not say no to patients and are paid more to provide more care; tort lawyers who argue negligence when not all that is possible is done for their client; and patients and their families who demand everything that might help be done because

cost should be of no concern if a third party is paying for it” (p. 420).

Another point to reconcile as we forge into the future of health care is that of the shift in point-of-care delivery. McDeavitt et al. (2012) point out that “health care is increasingly delivered by large organizations. As payment constraints tighten, it is likely that consolidation of providers will accelerate, with smaller hospitals being absorbed into larger systems” (p. 141).

Business change impacts case management in a number of ways, including the consolidation of case management roles and functions into existing staff positions and the use of unlicensed, nonclinical staff to address specific tasks. This is problematic because identifying and addressing barriers to care and health should not be moving further away from discovery during a comprehensive Bio-Psycho-Social-Spiritual assessment. As the use of checklists providing specific intervention activities expands, so does the risk of overlooking vital information that may not be collected by these efficiency-focused tools. When a barrier assessment is reduced to an oversimplified transaction, why would an organization pay for a clinical profession to do it when a less-qualified person will simply do as they are instructed? Nonclinical and underlicensed workers lack the education and training that ground the Critical Thinking competency. These actions also contribute to the defining, advanced intellectual and analytical skills that are the hallmark of an independent practitioner. While there is a definite role for nonclinical administrative support staff in the delivery of high-quality patient care, these valued members of the care team can never take the place of a professional case manager. “The use of nonclinical staff, as well as licensed individuals without appropriate education or training, to perform case management activities has already begun taking place. In this scenario, cost appears to be the driver for utilizing lower wage workers. The impact that this approach to staffing has on quality of care or value for service delivered has yet to be clearly and consistently demonstrated” (Treiger, 2011, p. 48).

There is also a risk of off-shoring case management services. As pointed out in a Remington Report article, “As the education, skill set, and sophistication of case management progresses, it is increasingly likely that there will be a rise in compensation. One risk associated with higher salary expense is the consideration by health care organizations to outsource case management responsibilities, in some cases to offshore entities. This potential scenario is another valid argument in favor of officially codifying case management into legislation and regulation to prevent the performance of activities requiring a specific level of clinical education and competency

to individuals without adequate knowledge gained through licensure, certification, education, or training within the United States healthcare system” (Treiger, 2011, p. 48).

If case management is to remain relevant in the future, our combined leadership must work synergistically to achieve the following:

- define professional case management practice and career paths,
- define case management’s value proposition,
- identify case management best practice, and
- define optimal consumer and organization-specific outcomes.

We achieve this by defining competencies for professional practice; ones that are agnostic to educational background, professional training, practice setting, population served, and licensure and/or certification. While there are certainly specialty-specific requirements that must be clearly documented, they should be touchstones on purposeful career paths geared to formal higher education degrees and certifications. A single-level certification may have been a giant leap forward 20 years ago, but today’s health care environment demands a more robust and organized framework to recognize knowledge, skill, and professional achievement.

Change and Best Practice

Because professional case managers are Big-Picture-Oriented, examining practices outside of case management is vital. It has become all too easy for some to embrace a defined best practice model simply because it is held up as such. The choice of a methodology should not come at the expense of a clear vision as to the implication of making significant changes within any organization. Hallencreutz and Turner (2011) raise interesting considerations pertaining to the use of best practice, the first of which is not having an accepted definition of best practice (within one’s organization) and the second being the lack of organization consensus on a best way to implement change (p. 61). A lesson learned in the business sector was how overreliance on best practice might lead to complacency in approaching change, “Not taking advantage of what change management has to offer, will almost certainly delay the project further, whereas systematic change management throughout the project can significantly speed up the project” (Garde, 2010, p. 405).

Finding a change management approach best suited for your organization may prove challenging. While Kotter is considered a “go to” model, Applebaum et al. (2012) pointed out that his model “appears to derive its popularity more from its



FIGURE 3
COLLABORATE® Queries.

direct and usable format than from any scientific consensus on the results” (p. 764). Ultimately, their review found support for most of Kotter’s approach, which was first published in his 1996 book, *Leading Change*. Although additional study was recommended, the straightforward steps would be a good point from which to begin. Figure 3 is an adaptation of Kotter’s steps and includes a few points to consider for each part of the process.

ORGANIZATIONAL CULTURE AMID OTHER INTEGRAL INFLUENCES

Culture does not change because we desire to change it. Culture changes when the organization is transformed—the culture reflects the realities of people working together every day.

—Frances Hesselbein

Navigating the culture of your environment is never easy. Transformation is difficult even when you have managed to get through similar efforts undertaken in the past. However, some level of cultural change is essential to implement COLLABORATE®. While this may present as a foreboding task, you may achieve greater clarity as to how to strategically position this effort by acknowledging three issues.

First, one must distinguish between and understand the concepts of *organizational culture* and *organizational climate*. Both serve to define the entity you are employed for by influencing how the industry stakeholders view it.

By definition, *organizational culture* is enduring and entrenched for it refers to the overt, observable attributes of an organization. These attributes include its mission, core values, and core characteristics. On the contrary, *organizational climate* is a far more fluid dynamic that consists of the temporary attitudes, feelings, and perceptions of the individuals employed by the organization. It takes into account any perspectives that are modified as situations change based on new information. In a nutshell, organizational culture refers to the way things are as opposed to

the *organizational climate* that encompasses the attitudes employees have about the culture (Cameron & Quinn, 2011, p. 21).

With respect to case management, an example of *organizational culture* might be to promote the belief that all engage in best practice to meet the needs of their target patient population. This is operationalized by the expectation that case managers achieve specialty certification, attend requisite continuing education programs, and strive for advanced degrees. However, the *organizational climate* finds that while employees want to embrace the culture, they are, in reality, resentful of it because professional education benefits were cut as part of budget reduction. As a result, case managers must pay out of pocket for the very education that the organization hired them for, and relies on them to maintain. This has resulted in significant personal financial impact for all clinical employees.

Some may contend that both *organizational culture* and *climate* are subjective and nebulous, though as Bellot (2011) frames *organizational culture* exists. To that end it cannot be avoided. It can be ambiguous, but it is unique to each institution and malleable. Every organization has a unique and distinct culture; each inherently fuzzy for they incorporate contradictions, paradoxes, ambiguities, and confusion (p. 33).

Second, one must recognize the underlying challenges that accompany any change to *organizational culture*. As Denning (2011) discusses, changing an *organization’s culture* is one of the most difficult leadership challenges, due in part to its complex composition of factors. *Organizational culture* comprises an interlocking set of factors including goals, roles, processes, values, communication practices, attitudes, and assumptions, each subject to the individual input of an array of involved stakeholders who bring their unique belief systems of best practice to the effort. While stakeholders present with the best intentions, the mutual competing and conflicting agendas meet the reality of the organization and a huge disconnect can occur. Implementation of the cultural transformation effort proceeds, hoping to yield profitable return on investment. Of course, this will be accomplished through the grand efforts, which accompany any restructuring and streamlining of department operations, including but not limited to the following:

- Reframing job roles and functions.
- Developing new titles for some, if not all of these jobs.
- Reallocating staff.
- Generally overhauling overall service delivery.

Of course, no one is quite sure if the outcomes will yield the return on investment estimated or, if so,

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over what timeframe, including those who developed the plan. After several fiscal quarters if that long, the plug is pulled on a cultural change effort that is no longer responding to life support despite massive resuscitation efforts. Everyone in the organization now breathes a huge sigh of relief, until the next great organizational culture change moment is recognized and the process begins anew. Consider your own employer and how many such restructuring efforts can you recall? Perhaps you developed situational amnesia or simply lost count.

Over the past 30 years, health care has endured its own cultural shift from care of the patient's health to the care of the business of health care (Fink-Samnicks, 2008, p. 338). Case managers lived through the ongoing shift by being flexible and accommodating evolving roles and functions that resulted from reorganization initiatives during their employment tenure. In fact, it should give pause to consider that 75% of reengineering, total quality management, strategic planning, and downsizing efforts fail entirely or create problems serious enough to threaten the survival of the organization (Cameron & Quinn, 2011, p. 1).

Third, assessing and diagnosing the culture are critical to moving forward. Case managers are trained to break down the complexities before them, whether organizational culture, interpersonal dynamics, and/or patients. A frequently used model is Cameron and Quinn's Organizational Culture Assessment Instrument (OCAI), based on their Competing Values Framework (Cameron & Quinn, 2011, p. 28). The OCAI's purpose is twofold; it is designed to help identify an organization's current culture. Then by using the same instrument, works to identify the culture employees believe should be developed, one to match future demands and opportunities anticipated over the next 5 years. Just as there is no right or wrong culture, the OCAI supports the same premise by noting that there are no right or wrong responses. Imagine the OCAI as the meeting of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis with a crystal ball (p. 29).

The OCAI is one of many options available to assess and diagnose cultural change. While it might present as an easy one to recommend, it is far from the only one. Given the diversity that underlies both the organizational culture and climate of each unique employer, readers are encouraged to explore

assessment methodologies to ascertain an appropriate match. Much like the art of diagnosing patients, ask any 10 case management leaders that assessment tools have worked for them and you will get 10 different recommendations. It may be helpful to begin with a few queries specific to your organization, as presented in Figure 4.

THE LEADERSHIP OF CHANGE

There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things.

—N. Machiavelli

So now you have identified the need for change in your organization. How exactly does one pursue making a change? In considering how we work with clients to make lasting change, this may not seem like a very wide chasm, but if it was so easy we would all be much further along the professional development path by now. It is critical to recognize and accept several factors.

There is a clear distinction between change management and change leadership that Kotter (2011) considers to be apples and oranges, "Change management, which is the term most everyone uses, refers to a set of basic tools or structures intended to keep any change effort under control. The goal is often to minimize the distractions and impacts of the change. Change leadership, on the other hand, concerns the driving forces, visions, and processes that fuel large-scale transformation. Both are integral principles for case managers to reconcile.

As a case manager, you are a leader, whether you are in a formal leadership role in that "C-Suite" or not. Case management leadership happens in every

Create a Sense of Urgency
• Use existing outcomes to make the case for necessary change
• Benchmark with similar organizations' outcomes
Creating the Guiding Coalition
• Consult with colleagues to gain consensus
• Document sub-optimal outcomes as evidence for change
Developing a Change Vision
• Evaluate similar change initiative results
• Make projections based on current trajectory versus if change instituted
Communicating the Vision for Buy-in
• Develop visual representations for greater impact
• Keep it simple and to the point
Empowering Broad-based Action
• Educate all levels of the organization
• Focus on WIIFM
Generating Short-term Wins
• Establish interim/milestone goals to foster sense of achievement
Never Letting Up
• Don't let popular trends derail effort
• Have confidence in your decisions
Incorporating Changes into the Culture
• Communicate your results across the organization
• Use bulletin board approach to graphically demonstrate outcomes

FIGURE 4
COLLABORATE® Queries Adapted from Kotter's process for leading change (1996).

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aspect of practice and professional identity (Treiger & Fink-Samnick, 2013b). Discussions with countless corporate directors of case management find an increasing trend, recognition of case managers as the drivers, if not team leaders, of the care coordination processes in their respective organizations. This is consistent with efforts by regulatory entities and initiatives, such as those framed by The Joint Commission (2012) and the Institutes of Medicine's (2010) *Future of Nursing*. It is noted by the Patient Protection and Affordable Care Act, which emphasizes case management's opportunity to lead the health care team, discussed extensively in Part I (Treiger & Fink-Samnick, 2013a, p. 125).

The current hot topic of hospital readmissions for Medicare beneficiaries within 30 days in October 2012 alone supports case management's powerful role on the transdisciplinary health care team as a facilitator of both change leadership and change management. Some in health care's transdisciplinary workforce saw the writing on the wall early on, which foretold the need to reframe discharge planning and care coordination interventions. Zander (2010) stated, “If case management is not given the authority to be the central coordinator of the multiple activities involved to prevent readmissions, responsibilities will remain divided and never be totally effective” (p. 190).

The fines ensued with an initial \$280 million in 2012 (Rau, 2012). As of August 2013, an additional \$227 million in fines were levied against hospitals in all but one state as part of a second go-round, impacting some 2225 facilities (Rau, 2013). Dr. Eric Coleman, a national expert on readmissions and Director of the care transitions program at University of Colorado, offered clear messaging to the industry,

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“People are starting to recognize that renaming discharge planning does not actually improve your readmissions rate” (Rau, 2013).

Case managers bring value to this arena by virtue of their education and training, including assessing and engaging in proactive interventions toward facilitation of the care process. Through operationalizing the key elements identified in COLLABORATE®'s Outcomes, Leadership, Advocacy, and Anticipatory competencies (Treiger & Fink-Samnick, 2013b, p. 220), case managers are primed to support the organizational imperatives that take on the challenges of committed quality management and performance improvement.

OBSTACLES TO CHANGE

All progress is precarious, and the solution of one problem brings us face to face with another problem.

—Martin Luther King Jr.

Understanding the barriers to change is a task undertaken by case managers each and every day. However, it is a task performed in the context of identifying obstacles faced by health care consumers, not by employers and certainly not those blocking personal and professional advancement. Probably the most significant influencer of incongruity is that one involves taking measure of someone else's problem, rather than focusing in one's own backyard. But if one is to honestly appraise the current state of case management practice, it requires critical examination of individual and collective performance. It is one thing to point and say, “this is what you should be doing” or “this is how you should be doing it” or “if you don't do it this way, you aren't really doing it.” But it is quite another matter to step up and take on the issue of professionalization of case management. Consider this, is it time for naysayers to give up the wheel and allow those with clearer vision of what lies ahead to drive?

Some may argue that a more measured approach be advisable. Well, okay. Let us stop and assess where we are now after having taken decades of measured steps. Has the conversation really changed that much from where it was last month, last year, or last century? If you think not, take a moment to mull over the fact that case managers continue to be manipulated

by the structures they work within. Bemoaning the lack of recognition of case management's value to the health care equation does not advance the practice. We can debate which credential is superior. We can divide our strength by splitting off into professional organizations that focus exclusively on practice setting or population served. Yes, we can continue to do all of those things (and more), but one can bet dollars to donuts that it will not move case management forward from the perspective of professional clinical practice. It will yield no shift in the positioning of case management from advanced practice to full-fledged profession. Case management will continue in neutral unless stakeholders across academia, professional organizations, and certification/accreditation bodies agree to work together in taking on the real challenges of transforming case management practitioners from mid-level functional technicians to warriors on a mission to transform health care delivery.

The time has come to collaborate, no pun intended. One is hard-pressed to see the benefit of continuing mutually exclusive efforts to advance recognition of case management. Working as partners will certainly improve the likelihood of attaining a consensus-driven definition and career paths for professional practice, defining our value proposition across the health care continuum, and identifying best practices, and leveraging meaningful outcomes. Why? Perhaps it is because individual efforts favor the needs of the few, rather than benefits for the many.

In 2013, the Effective Health Care Program issued its report addressing key questions regarding case management. The project, titled *Comparative Effectiveness of Case Management for Adults With Medical Illness and Complex Care Needs*, intended to determine the effectiveness of case management. However, the definition of case management that was used for the project was "a process in which a person (alone or in conjunction with a team) manages multiple aspects of a patient's care" (2013). Not familiar is it? One hazards to guess that this verbiage was used because there is not a single definition that the entirety of case management stands behind. Various organizations made minor modifications in the original definition as a way in which to distinguish themselves. If case management leaders cannot agree on a definition, it is not reasonable to expect others to select one over another.

The research that was selected and evaluated by the expert panel was identified as case management, but researchers recognized that heterogeneity of the included studies was problematic to ascertaining effectiveness due to the variance in factors such as practice scope, roles, functions, and activities. The Effective Health Care Program acknowledged that "Case managers typically performed multiple func-

tions. These included, but were not limited to, assessment and planning, patient education, care coordination, and clinical monitoring. In general, emphasis on specific functions varied according to patients' conditions and the primary objectives of specific case management (CM) interventions. For example, interventions among patients with cancer typically focused on coordination and navigation, while interventions for patients with diabetes and congestive heart failure (CHF) focused more on patient education (for self-management) and clinical monitoring. Most studies did not carefully measure the amount of effort case managers devoted to different functions, making it difficult to discern the degree to which emphasis on different case manager functions impacted CM effectiveness" (Hickam et al., 2013, p. 21).

The report examined three key questions (note Figures 5, 6, and 7). Findings were summarized as "on balance, CM had limited impact on patient-centered outcomes, quality of care, and resource utilization among patients with chronic medical illness. The most positive findings are that CM improves the quality of care, particularly for patients with serious illnesses that require complex treatments (cancer and human immunodeficiency virus). For a variety of medical conditions, CM improves self-management skills. CM also improves Quality of Life in some populations (CHF and cancer) and tends to improve satisfaction with care. For the caregivers of patients with dementia, targeted CM programs improve levels of stress, burden, and depression" (Hickam et al., 2013, p. ES-15).

The lack of strong and consistent evidence demonstrating case management interventions as a valuable asset in health care management is disappointing. Positive report findings would have provided a solid platform on which to catapult future work in the field. However, the findings that were uncovered could be leveraged as a tremendous opportunity to unite case management stakeholders, critically evaluate the findings, and use the lessons learned as a

Key Question 1: In adults with chronic medical illness and complex care needs, is case management effective in improving:

- a. Patient-centered outcomes, including mortality, quality of life, disease-specific health outcomes, avoidance of nursing home placement, and patient satisfaction with care?
- b. Quality of care, as indicated by disease-specific process measures, receipt of recommended health care services, adherence to therapy, missed appointments, patient selfmanagement, and changes in health behavior?
- c. Resource utilization, including overall financial cost, hospitalization rates, days in the hospital, emergency department use, and number of clinic visits (including primary care and other provider visits)?

FIGURE 5
Effective health care program: Key question 1.

Key Question 2: Does the effectiveness of case management differ according to patient characteristics, including but not limited to: particular medical conditions, number or type of comorbidities, patient age and socioeconomic status, social support, and/or level of formally assessed health risk?

FIGURE 6

Effective health care program: Key question 2.

springboard for charting a course for the future of collective practice improvement and success.

The distractions to unified practice improvement need to be carefully evaluated because they may prove themselves to be inconsequential in hindsight. It is time to be audacious. It is time to take a stand within the health care community. We must put aside any long-standing debates about case management and place professional survival on the fast track. Failing this, case management may be doomed to remain in the shadows unable to maintain its relevance as health care delivery continues to progress.

COMPETENCY-BASED EDUCATION LEADING TO COMPETENCY-BASED PRACTICE

Competency-based methodologies have grounded academia and licensure regulation for the past decade, as discussed in Part I (Treiger & Fink-Samnick, 2013a, p. 131). However, despite operationalizing professional and discipline-specific competencies with their related practice behaviors, students and new professionals continue to voice concerns about the relevance of theoretical content to the real world. Potential employers echo this concern through recent surveys, with one from Hart Research Associates providing compelling validation. Ninety-three percent of the employers surveyed identified that a candidate's ability to demonstrate the capacity to think critically,

Key Question 3: Does the effectiveness of case management differ according to intervention characteristics, including but not limited to: practice or health care system setting; case manager experience, training, or skills; case management intensity, duration, and integration with other care providers; and the specific functions performed by case managers?

FIGURE 7

Effective health care program: Key question 3.

communicate clearly, and solve complex problems was far more important than what their undergraduate major may have been. Seventy-five percent indicated that colleges should place increased emphasis on competencies that reflect critical thinking, complex problem-solving, written and oral communications, and applied knowledge in real-world settings. How can new graduates demonstrate to potential employers they have actually mastered these competencies no matter what their major (Tempera, 2013)?

Individuals who pursue higher education should expect a new methodology to assess the outcome(s) of academia's current competency-based approach. An innovative examination promises to accomplish this task in the spring when administered to some 200 colleges and universities. The Collegiate Learning Assessment Plus, developed by the Council for Aid to Education, will test the critical thinking ability of graduates. Time will tell what the evidence will show, although experts expect that it will support the value of competency-based learning as the new standard of academic practice.

As explored in Part I (Treiger & Fink-Samnick, 2013a, p. 132), this competency-based organizational culture change is in sync with the competency-based domains identified by the Interprofessional Education Collaborative. Add the Collegiate Learning Assessment Plus to all other competency-based models presented through Parts I and II of this article series and validation for COLLABORATE® is further supported.

CONCLUSION

As we strive to ensure consistent, top-notch case management practice in a constantly changing health care environment, any attempt to wrap this article series up with a neat bow would discount the emphasis we have placed on flexibility in response to ongoing challenges and dedication to continual learning.

It is time to take a stand within the health care community. We must put aside any long-standing debates about case management and place professional survival on the fast track. Failing this, case management may be doomed to remain in the shadows unable to maintain its relevance as health care delivery continues to progress.

These articles are just the first volley over the bow of case management practice. We challenge you, our valued colleagues, to engage in the important dialogues that impact your career, to pursue performance excellence in your professional practice, and never to forget that the medical record you touch, the computer screen you look at, and the telephone call you make or receive in some way affects the health and well-being of a human being. Although some of our tasks may seem rather rote by their very nature, it is critically important that we undertake our responsibilities with professionalism and pride. The COLLABORATE® competency-based model provides a framework for delivering high-quality case management service. One question remains: are you ready to make the paradigm shift?

If you always do what you've always done, you'll always get what you've always got.

—Anonymous

REFERENCES

- Appelbaum, S. H., Habashy, S., Malo, J., Shafiq, H. (2012). Back to the future: Revisiting Kotter's 1996 change model. *Journal of Management Development*, 31(8), 764–82. DOI: 10.1108/02621711211253231.
- Ballot, J. (2011). Defining and assessing organizational culture. *Nursing Forum*, 46(1), 29–37.
- Blank, R. H. (2012). Transformation of the US healthcare system: Why is change so difficult? *Current Sociology*, 60, 415. DOI: 10.1177/0011392112438327. Retrieved August 13, 2013, from <http://csi.sagepub.com/content/60/4/415>
- Cameron, K., & Quinn, R. (2011). *Diagnosing and changing organizational culture* (3rd ed.). Jossey-Bass. San Francisco, CA.
- Christo and Jean Claude (2013). *Artist website*. Retrieved September 6, 2013, from <http://www.christojeanneclaude.net>
- Commonwealth Fund. (2011). *Why not the best? Results from the national scorecard on U.S. health system performance, 2011*. Washington, DC: The Commonwealth Fund Commission on a High Performance Health System.
- Cuellar, A. E., & Gertler, P. J. (2003). *Trends in hospital consolidation: The Formation of local systems; health affairs*. Retrieved September 4, 2013, from <http://content.healthaffairs.org/content/22/6/77.long>
- Demonstrate your value to retain, add case management staff. (2012). Hospital Case Management, pp. 33–35. Retrieved September 1, 2013, from <http://search.proquest.com/docview/964017234?accountid=458>
- Denning, S. (2011). *How do you change an organizational culture*. Retrieved August 31, 2013, from <http://www.forbes.com/sites/stvedenning/2011/07/23/how-do-you-change-an-organizational-culture>
- Fink-Samnick, E. (2008). Developing a resilience accountability continuum: Workplace resilience, Part 2. *Professional Case Management*, 13(6), 338–343.
- Garde, S. (2010). Change management—An overview. *Studies in Health Technology and Informatics*, 151, 404–412.
- Hallencreutz, J., & Turner, D. M. (2011). Exploring organizational change best practice: Are there any clear-cut models and definitions? *International Journal of Quality and Service Sciences*, 3(1), 60–68. Retrieved September 1, 2013, from <http://www.emeraldinsight.com/journals.htm?issn=1756-669X>
- Hernandez, S. R., & Shewchuk, R. M. (2011). Working toward effective change in healthcare. *The Journal of Health Administration Education*.
- Hickam, D. H., Weiss, J. W., Guise, J.-M., Buckley, D., Motu'apuaka, M., Graham, E., ... Saha, S. (2013, January). Outpatient case management for adults with medical illness and complex care needs. *Comparative Effectiveness Review*, 99. (Prepared by the Oregon Evidence-based Practice Center under Contract No. 290-2007-10057-I.) AHRQ Publication No. 13-EHC031-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved June 15, 2013, from <http://www.effectivehealthcare.ahrq.gov/reports/final.cfm>
- Institutes of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.
- Kotter, J. (2011). *Change management vs. change leadership: What's the difference*, forbes. Retrieved August 30, 2013, from <http://www.forbes.com/sites/johnkotter/2011/07/12/change-management-vs-change-leadership-whats-the-difference>
- Kotter, J. (2012). *Leading change*. Harvard Business Review Press, Boston, MA.
- McDeavitt, J. T., Wade, K. E., Smith, R. E., & Worsowicz, G. (2012, February). Understanding change management. *Physical Medicine and Rehabilitation*, 4, 141–143. DOI: 10.1016/j.pmrj.2011.12.001.
- Rau, J. (2012). Medicare to penalize 2,217 hospitals for excess readmissions. *Kaiser Health News*. Retrieved September 9, 2013, from <http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx>
- Rau, J. (2013). Armed with bigger fines, Medicare to punish 2,225 hospitals for excess readmissions. *Kaiser Health News*. Retrieved September 8, 2013, from <http://www.kaiserhealthnews.org/stories/2013/august/02/readmission-penalties-medicare-hospitals-year-two.aspx>
- Tempera, J. (2013). Post-college exam seeks to determine employability. *USA Today*. Retrieved August 30, 2013, from <http://www.usatoday.com/story/news/nation/2013/08/29/learning-assessment-plus-test-colleges-employers/2726031>
- The Joint Commission. (2012). *Hot topics in health care, transitions of care: The need for a more effective approach to continuing patient care*. Retrieved August 29, 2013, from http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf
- Treiger, T. (2011). Case management: Prospects in definition, education, and settings of practice. *The Remington Report*, 19(1), 46–48.
- Treiger, T. M., & Fink-Samnick, E. (2013a). COLLABORATE®: A universal, competency-based paradigm for professional case management practice, part I. *Professional Case Management*, 18(3), 122–135.

Treiger, T. M., & Fink-Samnack, E. (2013b). COLLABORATE®: A universal, competency-based paradigm for professional case management practice, part II. *Professional Case Management*, 18(5), 219–243.

Zander, K. (2010). Case management accountability for safe, smooth, and sustained transitions. *Professional Case Management*, 15(4), 188–199.

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