Mentoring New Case Managers, Articulating Local Knowledge. Patricia Benner, R.N., Ph.D. FAAN June 18, 2019

I will use our research on Case Management in the Transport System of Health Care from the Military to The Veteran's Administration. This research illustrates the kinds of local, and informal knowledge that Case Managers need to know in this radically changed health care delivery system in the Military, VA, and finally home care. In this study we identified the following. Mentoring in such a rapidly changing field is essential for the transmission of local knowledge and skills to be an excellent Case Manager.

The Evolution of Case Management for Service Members Injured in Iraq and Afghanistan
Patricia Watts Kelley1, Deborah J. Kenny2, Deborah R. Gordon3, and Patricia Benner3
Qualitative Health Research. 2015, Vol. 25(3) 426–439.

Below are functions and examples of the Case Manager's Roles in Military Care with examples of the local knowledge involved. Direct Quotes are italicized.

Case Managers Manage Patient Transitions:

> *Case management has been described as "the central component that ensures seamless patient transitions throughout the rehabilitation and recovery continuum" (Perla et al., 2013, p. 231). This formal abstract definition of case management fits the various case management roles in the military and VA health care systems. The U.S. Department of Defense (DoD) and the VA work closely together to provide comprehensive care coordination and case management for service members and veterans. This coordination/management function has been given several names, forms, and sites throughout the military health care system. For the purposes of this article, we will define CM as being inclusive of, but not limited to, similar positions of each of the branches of the military health care system that advocate and coordinate the care for particular WSMs' injuries, concerns, and care trajectories.1*
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> *These CM roles have expanded to provide the necessary continuity and coherence of care to injured WSMs as they transition from war injury, acute care, recovery, rehabilitation, and reentry to home. Thus, traditional abstract definitions of the role miss much of the new*

knowledge and skill demanded in dealing with this unique and young WSM population and this new and complex health care delivery. More articulation of what is required, what actually takes place in the field, and what constitutes good and substandard care as experienced first hand is needed. Within this article, we seek to fill in some of these gaps in understanding in the specific and rarified context of the military.

One Goal of this presentation is to have Case Management Mentors to think about the local knowledge, and the unique roles, intentions, and functions of Case Managers in your own area of practice. A Second goal is to have you think about how your work of mentoring new Case Managers increases the reliability of your health care institutions(s). The following functions and care goals of these Military Case Managers were:

(1) Meeting, knowing, and tracking patients' past, present, and future.

We take the whole roll of incoming patients from downrange [the front]—foreign, military, and civilian. On a weekly basis CMs divide the list among us, and we find every patient. Because sometimes patients forget to see a CM. We are always tracking where everyone is, and if they haven't seen a CM, we wheel them in and track what has been going on with them, and then become kind of archeologists and track everything that's gone on while they were here. Usually the ones that are lost find us, because they don't know where to go. We track them until they leave. (CM)

(2) Simplifying the point of contact within and between institutions

We are constantly reworking to make everything cohesive so we can cut down the confusion for the patient and the family. Because that's what service members and family members told the Commission [Presidential Commission on Care of the Wounded]: "It's too chaotic. We have too many case managers. We move from facility to facility, and we need one point of contact that we can call when things go awry." So that was the main mission of our program. So I feel like there's been a lot of obstacles that keep popping up…and that it becomes more and more obvious that the connections are needed between the sectors. (CM)

(3) Knowing the patient and integrating and coordinating care.

I like my case manager. She really takes care of me. Something needs to be done, she'll personally go up there and do it. Like, instead of making a phone call, she'll walk over there and personally take care of it. She makes sure it gets done. And then she'll call me immediately and tell me what happened. My case manager calls me more than my wife does. (WSM)

(4) The case manager as patient advocate.

She's like a mother to me, she's amazing.…She's done absolutely everything I've ever needed down here. She was the one that actually fixed that problem [with my pain medication] when I was so ill in the barracks.…I called her when I got up that day, and she was like, "You need to

come back in [to the hospital]. Let's go to the emergency room." And I was saying, "No, no, it's not that big of a deal. Don't worry about it!" And she said, "No, I'm going to come over there and get you right now." I was up all night just throwing up, and I didn't want to make a big thing out of it. But she's done everything for me. She's amazing. All my appointments, I would have been lost without her. She's basically taken my hand and walked me to everywhere I needed to be in the hospital for my follow-up appointments. And she told me she would go with me to them if I wanted, and I was like, "No, I'm good." Yeah, I would have been walking in circles pretty medicated in the hospital if it wasn't for her. (WSM)

(5) Supporting and integrating the family into the health care team.

I was in a coma, and I had severe TBI, so I couldn't really explain to my family what was going on or how these things work. They couldn't ask me the questions they wanted to ask me. And mine is not really a military family; they don't have a lot of experience with it. So it really helped out to have that [CM] connection, to talk them through the whole thing. (WSM)

(6) Advocating for adequate supportive living environments.

He [the patient] had a tracheostomy, high cord injury, and has quadriplegia.…So we're going through a crisis now, transitioning from the hospital…making good gains, to going to a more remote area where there's not the same resources available. And although my exposure to distant community resources is minimal, staff nurses have even less exposure on how to accommodate somebody with so many needs into care in the community and also address care needs with the VA. So we're working through all that. (CM)

(7) The case manager as life and health coach.

This patient needs to be in an internship. For after they get done with their aggressive rehab, they will have a lot of time on their hands.…During this time is when anecdotally I've noticed a lot of the patients get into trouble. They start drinking, they'll go out and party; some of them pop positive on random urine screens. The chain of command needs to get them involved in vocational rehabilitation, go work on their resume. They need to direct these kids; they've been directed forever. They were directed to march, they go from boot camp to Marine combat training to infantry training or to wherever, and now all the sudden they're a wounded service member without a leg. They're loosely organized in the barracks, and they need to be positively directed. We try to get them enrolled in other things. (CM)

These role functions and areas of local knowledge are given to stimulate your own reflection and articulation of the local knowledge involved in your work as a Case Manager.