CCM
THE CENTER FOR CASE MANAGEMENT

New Definition

Karen Zander RN, MS, CMAC, FAAN: Editor

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Planning for the Day, the Pay, the Stay, and the Way*

By Karen Zander, RN, MS, CMAC, FAAN

Introduction: Ambiguity in Case Management-related Responsibilities**

1. When the physical therapy department calls to say that they cannot send a therapist to ambulate Mrs. Jones today because of sick calls, should nursing or case management fill in the void and walk the patient?
2. When the doctor says the patient cannot be discharged until the patient is cleared by the infectious disease consult and the cardiologist, who's responsibility is it to call those MDs?
3. When the child's family announces that they want their son to go to the rehab hospital that the doctor suggested, and the case manager knows that their insurance won't cover it, who's responsibility is it to discuss this with the family?
4. When the case manager notices that a patient hasn't received the hypertension medication ordered 8 hours ago, who should she tell?

These are only a few of the myriad of situations that arise every day for case managers and others as we try to move patients correctly toward clinical outcomes and the next level of care. Much of CCM's current consultation about case management and related functions has been about role clarification: "Who—nurses, case managers, social workers, doctors—should do what?" This confusion may be the result of poor model design, but it may also be the result of multiple priorities within extremely complex and pressured work environments. The main cause is certainly not due to everyone wanting everyone else's job! In CCM's experience, there has been significant slippage in the traditional roles and expectations of doctors, nurses, and social workers. In the past, there were usually enough of the same experienced people in the same roles day after day to provide the sense of order and stability. Professionals did not have to renegotiate their priorities and roles every day, every patient. Nowadays, this is the exception rather than the norm.

Guide for Role Clarification: Who Manages the Plans for the Day, the Pay, the Stay, and the Way?

Acknowledging that every situation is different, and that there should always be flexibility when it comes to patient care, CCM has developed the following role descriptions and differentiation chart that can be applied to most short and long term acute care organizations.

***Plan for the DAY** (the transaction level)...brought to you by the Staff RN working collaboratively*. All caregivers make their plans for interactions with the patient, whether the intervention is a few minutes or over a period of an hour, a shift, a visit, or a day. These plans are driven by a combination of MD orders, patient needs, and time. The staff RN responsible for

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Planning for the Day,...

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the patient each shift, directly or through nurses' aides, is the point person for pulling together and assuring the daily plan, determining that all treatments, tests, and therapies are performed and sequenced to continue the patient's progress toward clinical outcomes. Clinical paths, secretaries, and others support this effort.

Plan for the Stay *(Period from Crisis to Stabilization)... brought to you by the Case Manager working with systems*. Case managers provide decision support to the direct caregivers and MDs, using information, synthesis, and creativity. They pace the team and the system to ensure that both margin and mission (clinical outcomes) are met within quality standards. They are responsible for integrating the Plan for the Day into the broader Plan for the Stay, and for arranging for safe and smooth transitions between levels of care.

Plan for the Pay *(reimbursement for work)...brought to you by the Case Manager connecting the payer with the provider*. Case managers work closely with finance, business offices, MDs, coders, and others to ensure that the interventions of all professionals and departments will be and are reimbursed.

Plan for the Way *(solutions and changes for recovery and health)...brought to you by health care specialists in their field*. The way extends beyond the stay. It includes professionals that provide a wide range of special assistance along each patient and family's personal continuum; ie. helping families make difficult decisions, helping patients make life-style changes, negotiating and procuring individualized plans of care and resources for that care, programs of prevention, and disease management.

There are at least two principles that should be considered when clarifying roles. First, nurses—whether case managers or clinical staff nurses— should not be resolving clinical questions or disagreements between physicians. Second, everyone should be able to help out as much as they are legally and skill-wise able when other staff are short, but as the saying goes: "a favor soon becomes an obligation". If one person or department is rarely or inconsistently fulfilling their responsibilities, the problem should be brought to the attention of the larger group. If you are always in the position of helping out, you cannot get your own work accomplished.

To further clarify, The Center for Case Management also offers a basic table to adapt as you discuss implications of role clarification throughout a patient's admission. *(See Figure 1)*

Summary

The information here cannot directly answer the questions included in the opening four examples, but they can be used as a springboard for discussion and negotiation. One of the most useful and immediate actions is to have a series of brief meetings between the case managers, the nurse managers, the social workers, and any hospitalists or other MDs covering particular clinical areas to discuss what you can each do for the other, and how to stay patient-centered. You would be surprised at how many assumptions are made and how this simple intervention can help build bridges between departments.

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* The terminology "Plan for the Day and Stay" are courtesy of Judy Hayes, RN, MS, Director of Professional Practice, Quality and Staff Development at Brigham & Women's Hospital in Boston, MA. Appreciation to Jackie Somerville, RN, MS, Assoc. Chief Nurse/Patient Care Services at Massachusetts General Hospital for the concept of "Holding the Patient's Story."

**** YOUR TURN**

What are your answers to the first 4 questions at the beginning of this article? Please submit yours via email to *KZander@cfcm.com* or fax to 508-655-0858. Make sure to tell us if it is permissible to print them in the next issue!

Figure 1

Recommended Role Differentiation Chart

Role/Functions	RN Charge Nurse or Primary Nurse *(Report to Nurse Manager)*	Case Manager *(Reports to Director, CM)*	Social Worker
Focus = ❖	❖ **Create, coordinate, and deliver the "Plan for the Day"** • Support outcome-driven, evidence-based practices • Hold, interpret, and integrate the patient's story • Symptom relief • Safety	❖ **Manage "Plan for the Stay and Pay"** • Manage transitions and patient expectations • Manage payer & benefits • Provide decision support to MDs • ADL/function • Compliance	❖ **Facilitate "Plan for the Way"** • Ambassador to community through families • Manage family expectations • Provide support for crises and decision-making with specific interventions for high risk situations and indigent
Admission	• Do or review initial nursing assessment • Check advanced directives • Ensure appropriate Clinical Path placement *– Refer to social worker if patient is high risk* *– If readmission, call team meeting*	• Meet Patient; explain role & services to be provided • Anticipate LOS, outcomes, and next level of care *– Refer to social worker if patient is high risk* *– If readmission, call team meeting*	• Contact families on admission (with permission of patient) to: – extend comfort – identify spokesman – determine "willing, able, available" *– If readmission, call team meeting*
Daily Required	• Attend & participate in nursing report • Problem solve clinical and patient flow issues • Document in medical record if the direct care provider • Require timeliness from labs, therapies, and testing departments	• 100% Review regardless of patient's payer sources • Secure reimbursement • Determine next level of care based on disease trajectory, ADLs, and patient/family wishes • Conduct daily care coordination or DP rounds to develop Discharge Plan A & B and document daily status notes in **medical record**	• Identify and secure social services for those anticipated to have trouble meeting IADLs (Instrumental Activities of Daily Living such as shopping, banking, cooking, driving, etc.)
As necessary or referred (may be daily)	• Round with physicians • Conduct team briefings as needed	• Round with physicians	• Communicate with family spokesman • Crisis intervention with patients & families • Conduct family meetings • Assist families with decision-making
Discharge / Transfer	• Document outcome attainment • Provide RN to RN verbal reports	• Negotiate transitions • Complete forms • Provide CM to CM verbal reports	• Assist team and family as needed to create a smooth transition • Complete forms • Provide SW to SW verbal report