SPECIAL  SECTION

ON THE RIGHT PATH

Collaborative Case Management Makes Nurses Partners in The Care-Planning Process

BY JUDY LONDON, RN

The quality improvement movement in healthcare has resulted in two major changes in patient care: It has broken down barriers between hospital departments and reshaped systems for the patient's benefit. At Mercy Health Center, Oklahoma City, nurses have played a leading role in both these changes, most notably in developing and implementing collaborative care (case) management processes.

Traditionally, nurses have been coordinators of care. In the case management model, nurses become true collaborators in the patient care process. They no longer simply take orders, but actively participate in designing a plan of care.

Breaking Down Barriers

Collaborative case management is a multidisciplinary approach to patient care. It involves the development of "clinical pathways," plans of care for a single diagnosis as directed by a specific physician or group of physicians. From a certain pathway, an organized care "map" (multidiscipline action plan) is developed and individualized to meet the needs of each patient.

In developing these plans, the nurse works directly with the physician and personnel from all other hospital departments involved in patient care, such as radiology, laboratory, physical medicine, pharmacy, quality management, food and nutrition, home health, and pastoral care. As the relationships mature, everyone involved begins to speak the same language and to learn more about the role various disciplines play in patient care. In the process what was once a "nursing care plan" now becomes a "patient care plan."

In addition to breaking down departmental barriers, collaborative case management also removes barriers between physicians and nurses. While nurses have always coordinated the care of the patient, they now become a partner in initiating the care and setting goals for the patient. One

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Summary The quality improvement movement in healthcare has given nurses a greater role in developing and implementing collaborative case management processes. In the case management model, nurses no longer simply take orders but actively participate in designing a plan of care.

At Mercy Health Center, Oklahoma City, nurses play a leading role in the development of "clinical pathways," plans of care for a single diagnosis as directed by a specific physician or group of physicians. The pathways promote multidisciplinary, interdepartmental cooperation in patient care.

Since August 1992, Mercy has developed clinical pathways for five inpatient and outpatient procedures, and more are being considered. Once a plan has been created, its key points are rewritten in lay terms and printed in a brochure for the patient. During the treatment, nurses and other healthcare professionals document when specific steps in the plan have been completed.

In follow-up evaluations Mercy's steering committee for the collaborative care process has found that the clinical pathways have maximized quality, improved efficiency, increased patient satisfaction, and enhanced collaborative team practice.

key to this partnership is that everyone has access to all the information relevant to the patient care process.

Good communication is critical to effectively implement this system. It is not enough for managers to understand the system's basic rationale. All nurses and health professionals involved in the process must also grasp the concept. Mercy involves nurses and healthcare professionals throughout the hospital in developing the clinical pathways. We also have 90-minute training programs for all departments that will be directly involved with a particular pathway.

Reshaping Systems

Since planners decided to begin implementing care paths in August 1992, Mercy has developed maps for five inpatient and outpatient procedures—total knee replacement, transurethral prostatectomy, coronary artery bypass, laparoscopic cholecystectomy, and traumatic hip replacement. The hospital is currently considering care maps for pneumonia and all orthopedic surgical procedures.

A steering committee for the case management process sets criteria for choosing procedures, evaluates the processes quarterly for quality and cost data, and gathers comments from those participating in or affected by the process. For a procedure or treatment to be considered for a care plan, the committee has determined it must:

- Be high volume
- Lend itself to care map organization
- Be multidisciplinary
- Be amenable to continuous quality improvement
- Enhance collaborative approaches to care

Once a process has been identified as appropriate for pathway development, an implementation committee, made up of representatives from all clinical areas involved in treating patients under that pathway, reviews all the records of the particular physician's (or group's) patients who had the procedure done in the past year. Each member of the multidisciplinary committee develops a list of daily clinical activities (e.g., administering medications, issuing diet or activity orders) that occur at least 75 percent of the time. All the information is compiled and then returned to the physician, who reviews it and makes any necessary modifications.

These predictable elements of patient care delivery are then written in a standard format, listing potential problems that may occur and matching them with appropriate interventions. This document becomes a day-by-day, and even hour-by-hour, plan for care used by all employees who work with that patient.

> Everyone has access to all the information relevant to the patient care process.

The plan's key points are then rewritten in lay terms and printed in a brochure for the patient. It tells the patient what to expect before, during, and after the procedure. The brochure also includes information on medications, medical equipment used, tests performed, and physical therapy activities.

When scheduled for a procedure, a patient receives much of this information from the physician's office staff and is then contacted by the nurse who will be the case manager. The nurse meets the patient at the hospital three to five days before the procedure, combining necessary diagnostic procedures with patient and family education. Any variations from the prewritten pathway, such as those made necessary by a medication allergy, are listed on an attached quality management report.

During the treatment, nurses and healthcare

MULTIDISCIPLINE ACTION PLAN

Mercy's multidiscipline action plans (or "maps") document steps care givers and others must take to complete a plan of care for a specific diagnosis. The map for total knee replacement is a nine-page document charting activities and tests involved in the procedure from the initial patient evaluation to discharge from the hospital.

The first page lists 12 possible patient problems arising from the procedure (e.g., "Potential alteration in self-care related to decreased mobility and/or disease process") along with expected outcomes (e.g., "Patient will be independent in ADLs with appropriate assistive devices as needed"). On discharge, the nurse case manager verifies whether the expected outcomes were achieved.

Subsequent pages chart daily action plans for the entire course of treatment. Each page has a grid with 10 boxes in which prescribed activities are listed. Activity categories are assessment; self-care/discharge plan; patient teaching; psycho/social; consults; tests; rest/activity; medical interventions; medications; and nutrition. Nurses and other care givers document the completion of each step in the care plan.

The map not only specifies required activities and interventions; it also familiarizes care givers with aspects of the care plan they may not be directly involved in. For example, a chaplain might consult the plan to see what nurses or social workers have already done to address a patient's anxieties about the care process.

On the final page of the map, care givers document variations from the clinical pathway that occurred during the treatment, citing the reason for the variance and explaining what action was taken.

professionals document when specific steps in the plan have been completed. The case manager reviews the care map at least twice a day during the hospital stay to verify that all activities are being conducted as planned. If anything is not marked as being completed, the care manager takes immediate follow-up action, documenting it on the quality management sheet for later review.

The care maps are currently kept with the patient's chart and are part of the permanent record. The hospital plans to have electronic care maps in operation within a year, accessible via bedside terminals throughout the facility.

The process appeals to nurses because it clearly defines the expectation for care during illness. They know from day one until discharge what the physician has in mind for all aspects of care. Because they can see the expected outcomes before the patient is admitted, nurses are now better able to plan and organize activities. Also, because the course of care is documented in a clearly retrievable format, it is not necessary to wade through pages and pages of a medical chart.

This process also gives nurses a chance to integrate all aspects of patient care into the time available. And it gives the nurse more opportunity to educate patients and families than ever before.

Monitoring Effectiveness

Mercy's follow-up evaluations of the collaborative care process indicate that the program has been a success. After the first pathways were implemented, the steering committee found that the maps truly provide the kind of direction care givers require. Few additional orders have been needed to provide care. The variance sheets document the changes needed to ensure we are delivering the kind of care we planned.

One concern some have with the use of care maps is that it can lead to "cookbook" medicine—where all patients undergo a predetermined course of treatment without consideration for their special needs. But Mercy providers have found that a well-constructed care map actually tends to have the opposite effect. By clarifying the routine steps of a process, the maps also help care givers see where a particular patient's needs differ from the norm. For example, care maps can be easily amended to accommodate patients with preexisting conditions such as allergies or heart problems. The map's definition of basic treatments and procedures enbles physicians and nurses to identify unusual care needs when they arise.

Patients treated under the process report they have been satisfied. They indicate that the brochures they receive answer many of their questions and give them a clear understanding of what their treatment will entail. Knowing what they should expect, they also have some control over their care—a major quality aspect of the process. If the patient can see that the planned care is not being delivered, he or she can intervene.

The program is also having a positive impact on the bottom line. The steering committee estimates that collaborative case management has saved Mercy Health Center about $80,000 per year on total knee replacements while enabling the hospital to deliver higher-quality care. Being able to plan allows us to use more efficient purchasing procedures and reduce supply inventories. Also, the process can potentially reduce length of stay because all necessary care can be provided in a predetermined time frame.

Despite these advantages, critical pathways do have some limitations. Since each pathway of care is highly individualized, creating one is a time-consuming job for an institution. A hospital cannot devote all its resources to converting to collaborative case management. Participants need to move carefully through the process, allowing time for the learning curve.

Nevertheless, the time constraints have become less of an obstacle than they were originally. In preparing the first care map (on total knee replacements), 14 staff worked approximately one-and-a-half days each collecting information on what activities a given treatment or procedure entails. However, experience has enabled the staff to streamline the process, and preparing the last care plan required on average only two-and-a-half hours each on the part of participating staff.

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Focus on the Patient

Overall, collaborative case management has many advantages, including maximized quality, improved efficiency, increased patient satisfaction, and enhanced collaborative team practice.

But the major advantage of the process is that it supports the basic goal of our quality management philosophy—keeping the customer at the center of our activities. By gathering and coordinating input from all personnel involved in patient care, we can attune our procedures to our clients' genuine needs. And by making patients more aware of their treatment plan, we enable them to become true collaborators in the care process. □