ORGANIZING PATIENT CARE
Learning Objectives

1. Get reacquainted with the Traditional Models of Organizing Patient Care their brief background as well as its advantages and disadvantages.

2. List the essential components of case management and disease management.

3. Know the different Leadership and Managerial Functions in Organizing Patient Care.
• FIRST and MIDDLE-LEVEL MANAGERS influence the organizing phase of the management process at the unit or department level.
• UNIT LEADER-MANAGER – determines how best to plan work activities so that organizational goals are met effectively and efficiently.
• **TOP LEVEL MANAGER** – influence on the philosophy and resources necessary for any selected care delivery system to be effective.
Leadership Roles and Management Functions Associated with Organizing Patient Care
LEADERSHIP ROLES

1. Periodically evaluates the effectiveness of the organizational structure for the delivery of patient care.

2. Determines if adequate resources and support exist before making any changes in the organization of patient care.

3. Inspires subordinates to achieve higher levels of education, clinical expertise, competency, and experience in differentiated practice.

4. Ensures that chosen nursing care delivery models advance the practice of professional nursing.
5. Examines the human element in work redesign and supports personnel during adjustment to change.

6. Inspires the work group toward a team effort.
1. Examines the unit philosophy to ensure that it supports any change in the patient care delivery system.

2. Selects a patient care delivery system that is most appropriate to the needs of the patients being served.

3. Uses scientific research and current literature to analyze proposed changes in nursing care delivery models.

4. Uses a patient care delivery system that maximizes human and physical resources as well as time.
5. Ensures that nonprofessional staff are appropriately trained and supervised in the provision of care.

6. Organizes work activities to attain organizational goals.

7. Groups activities in a manner that facilitates communication and coordination within and between departments.

8. Organizes work so that it is as cost-effective as possible.
TRADITIONAL MODES OF ORGANIZING PATIENT CARE
TOTAL PATIENT CARE/ CASE METHOD NURSING

• Nurses assume total responsibility during their time on duty for meeting all the needs of assigned patients.

• Sometimes referred to as Case Method of Assignment.
• 19th Century – total patient care was provided in the homes.
• Great Depression of the 1930’s – people can no longer afford home care and began using hospitals. Nurses and students also became caregivers in hospitals and in public health agencies.

• 1930’s and 1940’s – hospitals grew and provided total care continued as the primary means of organizing patient care.
• Provides nurses with high autonomy and responsibility.
• Assigning patients is simple and direct.
• Lines of responsibility and accountability are clear.
• Patient theoretically receives holistic and unfragmented care during the nurse’s time on duty.
• The patient may receive three different approaches to care, often resulting in confusion for the patients.

• Requires highly skilled personnel and thus may cost more than some other forms of patient care.

• May result to unsafe care when Nurses have a heavy patient load.
FUNCTIONAL METHOD

• Personnel were assigned to complete certain tasks rather than care for specific patients.
• “Care through others” - Nurses became managers of care rather than direct care providers.

• UAP – Unlicensed Assistive Personnel
Patients

Medication Nurse

Treatment Nurse

Nurse

Nursing Assistants/ Hygienic Care

Clerical/ Housekeeping

Charged Nurse
- Evolved as a result of World War II and the Hill Burton Act.
- Continued due to the “Baby Boom” after the War.
• Economical means of providing care.
• Task are completed quickly with little confusion regarding responsibilities.
• Allows care to be provided with minimal number of nurses.
• Functions well in areas such as the operating room.
• May lead to fragmented care and the possibility of overlooking patient priority needs.
• May result to low job satisfaction.
• May not be too cost effective because of the need for many coordinators.
TEAM and MODULAR NURSING

• Ancillary personnel collaborate in providing care to a group of patients under the direction of a professional nurse.
• Developed in the 1950’s to decrease problems associated with functional organization of patient care.
• Nurse acts as a Team Leader responsible for knowing the condition and needs of all the patients assigned to the team and for planning individual care.

• Duties may include: assisting team members, giving direct personal care to patients, teaching and coordinating patient activities.
• A team should consist of not more than 5 people.

• Most team nursing was never practiced in its purest form but was in combination of team and functional structure.
MODULAR NURSING

MODULAR NURSING – a mini-team (2-3 members approach)

• Members are sometimes called “care pairs”.

• A small team requires less communication, allowing members better use of their time for direct patient care activities.
• Allows members to contribute their own special expertise or skill.

• Comprehensive care can be provided for patient despite a relatively high proportion of ancillary staff.
• Disadvantages are associated with improper implementation rather than with the philosophy itself.

e.g. insufficient time for team care planning and communication can lead to blurred lines of responsibility, errors and fragmented patient care.
PRIMARY NURSING

• Primary Nurse assumes 24-hour responsibility for planning the care of one or more patients from admission or the start of treatment to discharge or the treatment’s end.
• Also known as Relationship-based Nursing.

• Provides total direct care for patients.

• Requires a nursing staff made up of only Nurses.
• Developed in the 1970’s and uses some concepts of total patient care and brings nurses back to the bedside to provide clinical care.
• Associate Nurses – follows the care plan established by the primary nurse when the primary nurse is not on duty.

• This structure lends itself well to home health nursing, hospice nursing and other health care delivery enterprises.
• Clear interdisciplinary group communication and consistent, direct patient care by relatively few nursing staffs allows for holistic, high-quality patient care.

• High job satisfaction.
• Disadvantages in this method lie in improper implementation.

• Many nurses may be uncomfortable in this role due to lack of experience and skills necessary for the role.
CASE MANAGEMENT
• Introduced in the 1970’s by insurance companies as a method to monitor and control expensive health insurance claims.

• Today virtually every major health insurance company has a case management program to direct and manage the use of health care services for their clients.

• Known as external case management.
• Mid 1980’s hospitals had recognized the need for a case management model to manage treatment plans and length of stay of hospitalized patients.

• This was called internal case management or case management “within the walls” of the health care facility.
What is...

• A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes (CMSA, 2006)
• Focus is on individual patients, not populations of patient.

• Case managers handle each case individually, identifying the most cost-effective providers, treatments and care setting.
• Case Management Nurses can choose to specialize in treating people with diseases like HIV/AIDS or cancer, or you can work with patients of certain age groups like geriatrics or pediatrics.
• ACUTE-CARE CASE MANAGEMENT—integrates utilization management and discharge planning functions and may be unit based, assigned by patient, disease based, or primary nurse case managed.
• Additional work efficiency due to geographic proximity, but more importantly, the benefit of establishing solid working relationships with the nursing and ancillary staff working on the unit.

• In general a case manager can handle a load of 25 patients (Smith 2003)
• Use **Critical Pathways** and **Multidisciplinary Action Plans (MAPs)** to plan patient care.

• Care MAP – combination of Critical Pathway and Nursing Care Plans.
  – This indicates the time when nursing interventions should occur and this must be followed by health care providers.
  – Variance – anything that occurs to alter the patient’s progress through the normal critical path.
Cycle Time Reduction – involves reviewing the existing process that provides a product or service; determining wasted time or effort; and developing an improved, streamlined way to achieve the same results more efficiently. (Furlow 2003)
BECOME A CASE MANAGEMENT NURSE

GET YOUR...

Associate Science of Nursing (ASN)  Bachelors of Science in Nursing (BSN)

PASS YOUR...

National Council Licensure Examination (NCLEX-RN)

GET YOUR...

Case Management nurse certification from the American Nurses Credentialing Center

BECOME A...

CASE MANAGEMENT NURSE
• Effective case managers should have 3-5 years of direct care experience, preferably within the specialty area in which they case manage. (Smith 2003)

• Role should be reserved for the advance practice nurse or registered nurse with advance training (Huston 2002)
Qualities of a Case Manager

- Extremely Bright
- Well-developed interpersonal skills
- Able to multitask
- Strong foundation in utilization review
- Understands payer-patient specifics and hospital reimbursement mechanisms.
DISEASE MANAGEMENT

• One role increasing assumed by Case Managers is coordinating disease management programs.
• **DISEASE MANAGEMENT (DM)** – also known as *Population-Based Health Care* and continuous health care improvement, is a comprehensive, integrated approach to the health care reimbursement of high-cost, chronic illnesses.
• Includes early detection and early intervention as well as comprehensive tracking of patient outcomes.

• The difference of DM in Case Management is that the focus is on “covered lives” or populations of patients, rather than on the individual patient.
• GOAL: Serve the optimal number of covered lives required to reach operational and economic efficiency.
• National Committee for Quality Assurance (NCQA) – began an accreditation process in January 2002 for organizations that offer comprehensive DM programs.
Common Features

1. Focus is on prevention as well as early disease detection and intervention.
3. Employs multi-disciplinary health care team, including specialists.
4. Use standardized clinical guidelines – clinical pathways reflecting best practice research to guide providers.
5. Use integrated data management systems.

6. Frequently employs professional nurses in the role of case manager or program coordinator.
SELECTING THE OPTIMUM MODE OF ORGANIZING PATIENT CARE

• Most healthcare organizations use one or more modes to organize patient care.

• Europe currently is experiencing a rapid proliferation of primary nursing, while the United States has tended toward more functional and team nursing models that utilize support and ancillary staff (Nelson, 2000).

• Manthey (2001) is clear in her assertion that not all care must be provided by RNs, but states that the care delivery system chosen should be based on patient acuity and not on finances.
“Expecting similar performance from nurses with varying educational preparation can lead to role confusion, stress and burnout as nurses struggle to develop role competencies for which they have not been prepared.” (Fox 2003)
• Refers to an attempt to separate nursing practice roles based on education or experience or a combination of both.
2 BASIC DIFFERENTIATED PRACTICE MODELS

1. Education Model
   - Differentiation is based on type of educational preparation (AND, BSN, MSN)
   - Components: Provision of Care, Communication and management.

2. Competency Model
   - Based on individual nurse skill level, expertise and experience.
   - Benner’s five levels of practice (1984) and 8 ANA standards of nursing (novice, advanced beginner, competent, proficient, and expert).
Rationale

• To match patient needs with nursing competencies.
• Facilitate the effective and efficient use of nursing resources.
• Provide equitable compensation based on education, productivity and expertise.
• Increase nurse satisfaction.
• Build loyalty and increase the prestige of the nursing profession.
The Future for Patient Care and Delivery Models

• Nurse as clinical expert leading other members of a team of partners.
• Creation of a new nursing role (the clinical-nurse leader) that is more responsive to the realities of the modern health care system. (Tornabeni, Stanhope, and Wiggins 2006)
• A cooperative model of care delivery through lay care partners. They are taught to recognize systems, identify problems and take action.
5 Components of Determining the Model of Nursing Care Delivery (Reno et. Al 2005)

A. Conversion of manual systems into automated ones.
B. Differentiated levels of nursing practice.
C. Increased knowledge base of nursing practitioners.
D. Development of flexibility and nimbleness.
E. Attraction of nursing candidates from a more diverse pool of professionals.
When Evaluating the Current System and Considering a Change...
• Is it in line with the organizational philosophy? Does it facilitate or hinder organizational goals?

• Is it organized in a cost-effective manner?
• Will it satisfy the patient and their families?

• Will it provide some degree of fulfillment and role satisfaction to nursing personnel?

• Does it allow implementation of the nursing process?
• Does it promote and support the profession of nursing as both independent and interdependent?

• Does it facilitate adequate communication among all members of the health care team?
• How will it change the patient care delivery system, alter individual and group decision making? Will autonomy increase or decrease?

• How will social and interpersonal relationship change?

• Will the employees view their unit of work differently?
• Will the change require a wider or more restricted range of skills and abilities on the part of the caregiver?

• Will it change how employees receive feedback?

• Will communication patterns change?
I can't imagine writing nurses notes without my computer!

I'm using the computer, but I still rely on my written nurses notes.

Well, maybe a computer would be faster?

I can chart better on paper than I can on a computer.

Integration

Transference

Assimilation

Uncertainty

Resistance
Thank you