Make a plan

Plan for the way: Using clinical pathways and protocols and promoting open communication with medical providers, the IPCT can anticipate care needs and plan for efficient coordination (for example, testing, therapy evaluations, and family meetings).

Plan for the day: What's the patient's plan of care today? Each IPCT member is responsible for knowing his or her own plan for the patient each day and how it integrates with and impacts other team members' plans, including scheduled therapies, pending tests, and identified social issues. Members should use critical-thinking skills to identify potential barriers and issues along the continuum.

Plan for the stay: What milestones does the patient need to achieve before he or she is ready to transition to the next care setting or discharge? Have parameters been discussed and set for the patient? How does the IPCT coordinate care to achieve this goal?

Plan for the pay: Case managers ensure that patient services are assessed, planned, facilitated, and coordinated. In addition, they act as advocates for options and services to meet patient and family comprehensive health needs that promote quality, cost-effective outcomes. The case manager ensures the hospital receives payment for services and that the patient can access funding.