A COMMUNITY HOSPITAL’S UNIQUE AND NOVEL CARE MANAGEMENT PROGRAM

REDUCTION IN READMISSIONS & ENHANCED PATIENT PERCEPTION OF CARE
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St. Mary Medical Center

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Currently CNO – OSF Saint Anthony Medical Center
Presentation Outline

• BACKGROUND LEADING TO CARE MANAGEMENT CHANGES

• EFFECTIVE CARE MANAGEMENT OPERATIONAL STRATEGIES

• LESSONS LEARNED ASSOCIATED WITH CARE MANAGEMENT CHANGES

• STRATEGIES FOR COLLABORATIVE PARTNERSHIPS FOR EFFECTIVE CARE MANAGEMENT
I am entering the PowerPoint zone.

I no longer feel the need to change the real world as long as I can change these bullet points.

How much imaginary productivity did you have today?

Eight slides!
St. Mary Medical Center (SMMC)

- 200-Bed Full-Service Acute Care Hospital
- Located in Northwest Indiana – 30 miles outside Chicago
- Part of the Community Healthcare System
In 2010, Centers for Medicare and Medicaid Services (CMS) implemented the Readmissions Reduction Program as part of the Affordable Care Act.

- Hospitals financially penalized for readmissions within 30 days of discharge
- Three percent of a hospital’s Medicare reimbursement can be withheld based on the rate of 30 day readmissions for several diagnoses:
  - COPD
  - CHF
  - Hip and Knee
  - Pneumonia
  - CABG
  - AMI
SMMC Traditional Case Management Model
1970s - 2012

- Separate cost centers for Case Management and Social Services
- Unit specific case managers and social workers
- Case managers primarily focused on utilization review
- Clinical documentation and denials specialists operated in silos
- Utilization management technician single source of clerical support
Clinical Roles Impacting Case Management

- Stroke coordinator and pulmonary services navigator reported to manager of nursing quality
- Joint care coordinator reported to orthopedics nurse manager
- Heart failure nurse reported to telemetry nurse manager
- Functioned in silos
Why the Change?

Inefficient/Ineffective Case Management & Social Services

- Uncoordinated – multiple case managers & social workers per patient

- Disjointed & duplicative efforts – having to start over each time patient was transferred to another unit or phase of care

- Inconsistent vision & goals between the different leaders

- Unaligned with Affordable Care Act – episodic care versus population health

- LOS beyond geometric mean coupled with low acuity
Evolution of a New Care Management Model

The Birth of an Idea
Goals

To develop and implement a structure to support quality, cost effective care coordination by:

- Minimizing 30 day readmission rates
- Reducing length of stay consistent with national and regional benchmarks
- Enhancing patient perception of care
- Coordinating care across the continuum
Organizational Structure

Quality Care Coordination Department

Chief Nursing Officer

Administrative Director

Director
Case Mgmt
Social Services

Quality Care Navigator
Neuro/Urology

Quality Care Navigator
Pulmonary

Quality Care Navigator
Oncology

Quality Care Navigator
Cardiology

Quality Care Navigator
Ortho/Surgical

Manager
Nursing Quality

Coord. Prog
Dev
Data Analyst

Case Mgr Generalist
Case Mgr Analyst
Part Time Social Worker
UR Technician
Clinical Documentation Specialist
Denial Specialist

Case Mgr Social Worker

Case Mgr Social Worker

Case Mgr Social Worker

Case Mgr Social Worker

Case Mgr Social Worker
Administrative Director Role

Chief Nursing Officer

- Leader of quality care coordination department
- Ensures model integrity
  - Operations consistent with new department goals
- Coordinates efforts between
  - Care management
  - Denials management
  - Clinical documentation improvement

Manager Nursing Quality

Coord.Prog Dev Data Analyst

Administrative Director

- Director Case Mgmt Social Services
- Quality Care Navigator Neuro/Urology
- Quality Care Navigator Pulmonary
- Quality Care Navigator Oncology
- Quality Care Navigator Cardiology
- Quality Care Navigator Ortho/Surgical

- Case Mgr Generalist
- Case Mgr Analyst
- Part Time Social Worker
- UR Technician
- Clinical Documentation Specialist
- Denial Specialist

Case Mgr Social Worker
Case Mgr Social Worker
Case Mgr Social Worker
Case Mgr Social Worker
Case Mgr Social Worker

Data Analyst
Quality Care Navigator Role

- Nurses with disease specific expertise
  - Pulmonary
  - Neurology/ Urology
  - Oncology
  - Cardiology
  - Orthopedics/ Surgical
- Manages team of case manager and social worker
- Consistent quality care navigator for every patient admission
- Provides care management activities throughout the continuum of care - hospital through post-acute
- Manages patients for their entire lives
- Focuses on preventing readmissions
Case Manager & Social Worker Roles

Case Manager
- Focuses on reducing length of stay

Social Worker
- Focuses on discharge planning
- Both roles report directly to the quality care navigator
• Leadership responsibility for traditional case management/utilization review activities
  • Regulatory audits
  • Denials activities
  • Clinical documentation improvement
• Keeps abreast of impending regulations
• Communicates and recommends operational changes based on regulations
• Supervision of:
  • Case manager generalist
  • Case manager analyst
  • Part time social worker
  • Denials & clinical documentation specialist
  • Utilization review technician
• Provides care management for patients without a concrete diagnosis upon admission
Case Manager Analyst Role

• Analyzes data on all new admissions from the previous day to determine most appropriate quality care navigator assignment in order to best meet patient’s needs

• Provides coverage for disease specific case managers in times of vacations or leaves of absence
Part Time Social Worker & Utilization Review Technician Roles

Part Time Social Worker
- Provides coverage for disease specific social workers in times of vacations, leaves of absence, or as needed

Utilization Review Technician
- Focuses on obtaining insurance approvals for admission and continued stay
Coordinator Program Development & Data Analyst Roles

Coordinator Program Development
- Newly created role (conversion of prn social worker FTEs)
- Coordinates development of clinical programs and obtaining certifications or accreditations

Data Analyst
- Newly created role (conversion of prn social worker FTEs)
- Collects, analyzes, and distributes concurrent data to members of quality care coordination teams
- Inputs/prepares data collection for regulatory/certification agencies
## Financial Considerations

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Department #</th>
<th>FTES</th>
<th>Pre - Reorg</th>
<th>Post - Reorg</th>
<th>Labor Costs per pay period</th>
<th>Pre - Reorg</th>
<th>Post - Reorg</th>
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<tr>
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<td>4265</td>
<td>13.8</td>
<td>13.4</td>
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<td>$43,142</td>
<td>$40,273</td>
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<td>Orthopedics</td>
<td>1305</td>
<td>43.1</td>
<td>42.1</td>
<td></td>
<td>$87,786</td>
<td>$84,554</td>
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<td>Cardiovascular outpatient</td>
<td>2005</td>
<td>1.4</td>
<td>0.4</td>
<td></td>
<td>$4,888</td>
<td>$1,088</td>
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<tr>
<td>Case Management</td>
<td>4715</td>
<td>11.3</td>
<td>7.3</td>
<td></td>
<td>$29,074</td>
<td>$19,209</td>
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</tr>
<tr>
<td>Social Services</td>
<td>4700</td>
<td>5.1</td>
<td>0</td>
<td></td>
<td>$12,379</td>
<td>$0</td>
<td></td>
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<tr>
<td>Oncology</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
<td>$3,000</td>
<td>$0</td>
<td></td>
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<tr>
<td>Care Coordination</td>
<td>0</td>
<td>0</td>
<td>12.5</td>
<td></td>
<td>$0</td>
<td>$34,229</td>
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<td><strong>Totals</strong></td>
<td><strong>75.7</strong></td>
<td><strong>75.7</strong></td>
<td><strong>$180,269</strong></td>
<td><strong>$179,353</strong></td>
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</table>
Summary of Key Outcomes
Lessons Learned

Leadership Buy In

- Leadership Buy In
  - Lack of leadership buy-in
  - Leadership resistant to change
  - Leadership not flexible and open to modifications as the model developed and took more permanent shape

- Director of case management & social services position eliminated
- Pulmonary Quality Care Navigator promoted to Lead Navigator
- Social workers provided with secretarial support
Lessons Learned

- End of 2014 into 2015 - Dramatic staff turnover
  - This isn’t your mother’s case management model
  - Quality care navigator (QCN) role a unique position
    - Leadership skills
    - Clinical expert
    - Patient advocate
    - Excellent communicator
  - Many QCNs had clinical expertise but were not skilled or comfortable in leading people
  - Some Case Managers did not like reporting to a QCN
  - Training and team building – critical building blocks
- Leadership change made – New Administrative Director
Lessons Learned

- Continuum of care challenges
  - QCNs would see their own patients in the post-acute setting
  - Multiple QCNs could be at same post-acute venue at the same time
- Modified model so that one QCN did all the post-acute visits
  - Increased fragmentation
- Reverted back to QCNs performing own post-acute visits

Not all encompassing
Lessons Learned

- Unsuccessful in meeting readmission outcomes
- Eighteen percent increase in readmissions for 2016 vs 2015
- Assignment of patients by disease sites resulted in higher acuity/readmission potential for some teams
- Analysis of readmission patterns was performed
- QCN assignments were modified:
  - Ortho/Surgical
  - Oncology / GI
  - Neuro/Spine / A-Fib
  - Heart Failure/Pulmonary Treatment Clinic & CV Surgery
- Removal of utilization from case management
  - Increase patient satisfaction
  - Improve patient understanding of plan of care / discharge plan

Successful Outcomes

- Ortho/Surgical
- Low Risk Medically Complex
- Moderate Risk Medically Complex
- High Risk Medically Complex
Current Organizational Chart
Lessons Learned

• Readmission Risk Assessment
  • Conversion of manual risk assessment to use of the Lace + tool
    • 4-2019 Conversion to EPIC Analytics Readmission Tool

• Readmission Review
  • QCC involvement
  • Reason for readmission
  • Variables

• Limitations to the QCN home visit
  • Home Visits are limited to teaching and social support

Data is Essential

<table>
<thead>
<tr>
<th>Patient Scoring</th>
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<tbody>
<tr>
<td>Readmission Score:</td>
</tr>
<tr>
<td>Male Patient</td>
</tr>
<tr>
<td>LACE+ URGENT ADMISSION</td>
</tr>
<tr>
<td>LACE+ DISCHARGE INSTITUTION</td>
</tr>
<tr>
<td>Length of Stay</td>
</tr>
<tr>
<td>LACE+ ALC STATUS</td>
</tr>
<tr>
<td>ED Visits in Previous 6 Months</td>
</tr>
<tr>
<td>LACE+ NUMBER OF ELECTIVE ADMISSIONS IN PREVIOUS YEAR</td>
</tr>
<tr>
<td>LACE+ NUMBER OF URGENT ADMISSIONS IN PREVIOUS YEAR</td>
</tr>
</tbody>
</table>
Lessons Learned

- Post-acute visits by QCNs limited to teaching
- Addition of community paramedic
  - Contracted with ambulance company
  - Performs home visits on referred patients
    - Physical assessments
    - Consults with physician
    - Modifies medication dosages

Not all encompassing
Community Paramedic Logistics

- Reports to the Administrative Director of Patient Care Services
- Work hours are Monday through Friday 9AM to 5PM
- Paramedic office located in the hospital
- Eligible patients are determined by the QCNs and referred to paramedic
- Patient rounding is done by the patient’s QCN, in conjunction with the paramedic during the hospital event
- Patients sign enrollment form
Community Paramedic Logistics

- Paramedic contacts / visits patient on next business day after hospital discharge
  - Performs home safety assessment, medical assessment, medication reconciliation, and wellness assessment
  - Documents findings same day of visit
- Paramedic follows primary care physician (PCP) plan of care
  - Notifies PCP with any changes in patient condition
  - Contacts 911 for any emergencies and notifies the PCP
- Other duties
  - PCP visit(s)
  - Medication pick up
  - Wellness needs
# Paramedic Performance Score Card

## Community Healthcare System

### ST. MARY Medical Center

<table>
<thead>
<tr>
<th>METRIC</th>
<th>July 17</th>
<th>Aug 17</th>
<th>Sept 17</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Dec 17</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>March 18</th>
<th>April 18</th>
<th>May 18</th>
<th>June 18</th>
<th>YTD</th>
<th>Annual Target</th>
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<tbody>
<tr>
<td><strong>Volume</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Eligible Patients</td>
<td>45</td>
<td>46</td>
<td>64</td>
<td>57</td>
<td>54</td>
<td>65</td>
<td>79</td>
<td>52</td>
<td>94</td>
<td>67</td>
<td>78</td>
<td>55</td>
<td>756</td>
<td>**</td>
</tr>
<tr>
<td>Enrolled in Program</td>
<td>41</td>
<td>44</td>
<td>53</td>
<td>52</td>
<td>54</td>
<td>65</td>
<td>57</td>
<td>46</td>
<td>64</td>
<td>65</td>
<td>44</td>
<td>50</td>
<td>635</td>
<td>**</td>
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<tr>
<td>Active Enrolled</td>
<td>30</td>
<td>31</td>
<td>33</td>
<td>27</td>
<td>23</td>
<td>34</td>
<td>31</td>
<td>38</td>
<td>36</td>
<td>32</td>
<td>29</td>
<td>28</td>
<td>288</td>
<td>94% 50%</td>
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<tr>
<td>Number of Visits</td>
<td>101</td>
<td>129</td>
<td>114</td>
<td>120</td>
<td>86</td>
<td>112</td>
<td>116</td>
<td>75</td>
<td>87</td>
<td>94</td>
<td>47</td>
<td>72</td>
<td>1143</td>
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<tr>
<td><strong>30 Day Readmission Rates</strong></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Medicare ≥ CHF</td>
<td>23.5%</td>
<td>14.3%</td>
<td>15.8%</td>
<td>14.8%</td>
<td>9.5%</td>
<td>11.8%</td>
<td>22.2%</td>
<td>17.6%</td>
<td>23.4%</td>
<td>15.3%</td>
<td>20.8%</td>
<td>12.5%</td>
<td>18.8%</td>
<td>≤21.3</td>
</tr>
<tr>
<td>ALL CHF</td>
<td>18.5%</td>
<td>17.2%</td>
<td>11.4%</td>
<td>16.6%</td>
<td>11.8%</td>
<td>22.0%</td>
<td>21.3%</td>
<td>20.8%</td>
<td>21.7%</td>
<td>24.1%</td>
<td>20.4%</td>
<td>16.7%</td>
<td>18.7%</td>
<td>≤21.3</td>
</tr>
<tr>
<td>Medicare ≥ COPD</td>
<td>23.5%</td>
<td>0.0%</td>
<td>18.8%</td>
<td>9.1%</td>
<td>40.0%</td>
<td>25.0%</td>
<td>11.8%</td>
<td>16.7%</td>
<td>5.6%</td>
<td>36.4%</td>
<td>26.7%</td>
<td>18.2%</td>
<td>18.4%</td>
<td>≤15.2</td>
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<tr>
<td>ALL COPD</td>
<td>20.5%</td>
<td>2.7%</td>
<td>16.6%</td>
<td>21.1%</td>
<td>22.9%</td>
<td>26.5%</td>
<td>16.2%</td>
<td>21.4%</td>
<td>14.3%</td>
<td>14.7%</td>
<td>21.4%</td>
<td>14.3%</td>
<td>19.1%</td>
<td>≤15.2</td>
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<tr>
<td>Graduated from Program (30 days)</td>
<td>29</td>
<td>35</td>
<td>41</td>
<td>40</td>
<td>45</td>
<td>52</td>
<td>44</td>
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<td>50</td>
<td>55</td>
<td>36</td>
<td>45</td>
<td>510</td>
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### Performance Scorecard YTD

- **Fy 2011**
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>GOAL FY19</th>
<th>Overall</th>
<th>MC-1 (PN/CHF/COPD/AMI)</th>
<th>MC-2</th>
<th>MC-3</th>
<th>Cardiovascular (CABG)</th>
<th>Oncology</th>
<th>Ortho (HIP/KNEE)</th>
<th>Neuro (STROKE)</th>
<th>Unassigned</th>
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<tr>
<td>Nat’l Benchmark</td>
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<td>15.3</td>
<td>16.9 PN 21.6 CHF 19.8 COPD 16.3 AMI</td>
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<td>13.8</td>
<td>4.4</td>
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<tr>
<td>Hospital Compare</td>
<td>16.9</td>
<td>16.9</td>
<td>18.6 PN 24.3 CHF 22.5 COPD 16.4 AMI</td>
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<td>13.5</td>
<td>4.9</td>
<td>15.9</td>
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<tr>
<td>Medicare Only Readmit % *</td>
<td>≤ 15.0</td>
<td>NA (15.0)</td>
<td>NA (19.7)</td>
<td>NA (17.1)</td>
<td>NA (6.1)</td>
<td>NA (10.3)</td>
<td>NA (17.7)</td>
<td>NA (7.8)</td>
<td>NA (9.5)</td>
<td>NA (8.1)</td>
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<tr>
<td>Team Readmit %</td>
<td>≤ 13.7</td>
<td>NA (13.7)</td>
<td>NA (17.7)</td>
<td>NA (15.3)</td>
<td>NA (4.7)</td>
<td>NA (13.4)</td>
<td>NA (16.3)</td>
<td>NA (7.1)</td>
<td>NA (10.9)</td>
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<tr>
<td>Sepsis Readmit %</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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</tr>
<tr>
<td>ED Visit % *</td>
<td>3.38</td>
<td>0.12 (CHF) 1.49 (COPD)</td>
<td>0.86 (Dish) 0.63 (RF)</td>
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<td></td>
<td>0.27 (Stroke)</td>
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<tr>
<td>LOS *</td>
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<td>4.87</td>
<td>3.29</td>
<td>6.16</td>
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<td>1.2485</td>
<td>2.0721</td>
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<td>Nurses Kept You Informed</td>
<td>≥ 82</td>
<td>80.1</td>
<td>80.1</td>
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<td>80.1</td>
<td>80.1</td>
<td>80.1</td>
<td>80.1</td>
<td>80.1</td>
<td>80.1</td>
</tr>
</tbody>
</table>
THAT CONCLUDES MY TWO-HOUR PRESENTATION. ANY QUESTIONS?

DID YOU INTEND THE PRESENTATION TO BE INCOMPREHENSIBLE, OR DO YOU HAVE SOME SORT OF RARE "POWER-POINT" DISABILITY?

ARE THERE ANY QUESTIONS ABOUT THE CONTENT?

THERE WAS CONTENT?
QUESTIONS?