A COMMUNITY HOSPITAL'S UNIQUE AND NOVEL CARE MANAGEMENT PROGRAM

REDUCTION IN READMISSIONS & ENHANCED PATIENT PERCEPTION OF CARE

Kimberly Sgouroudis, RN, BSN

Administrative Director- Patient Care Services

St. Mary Medical Center

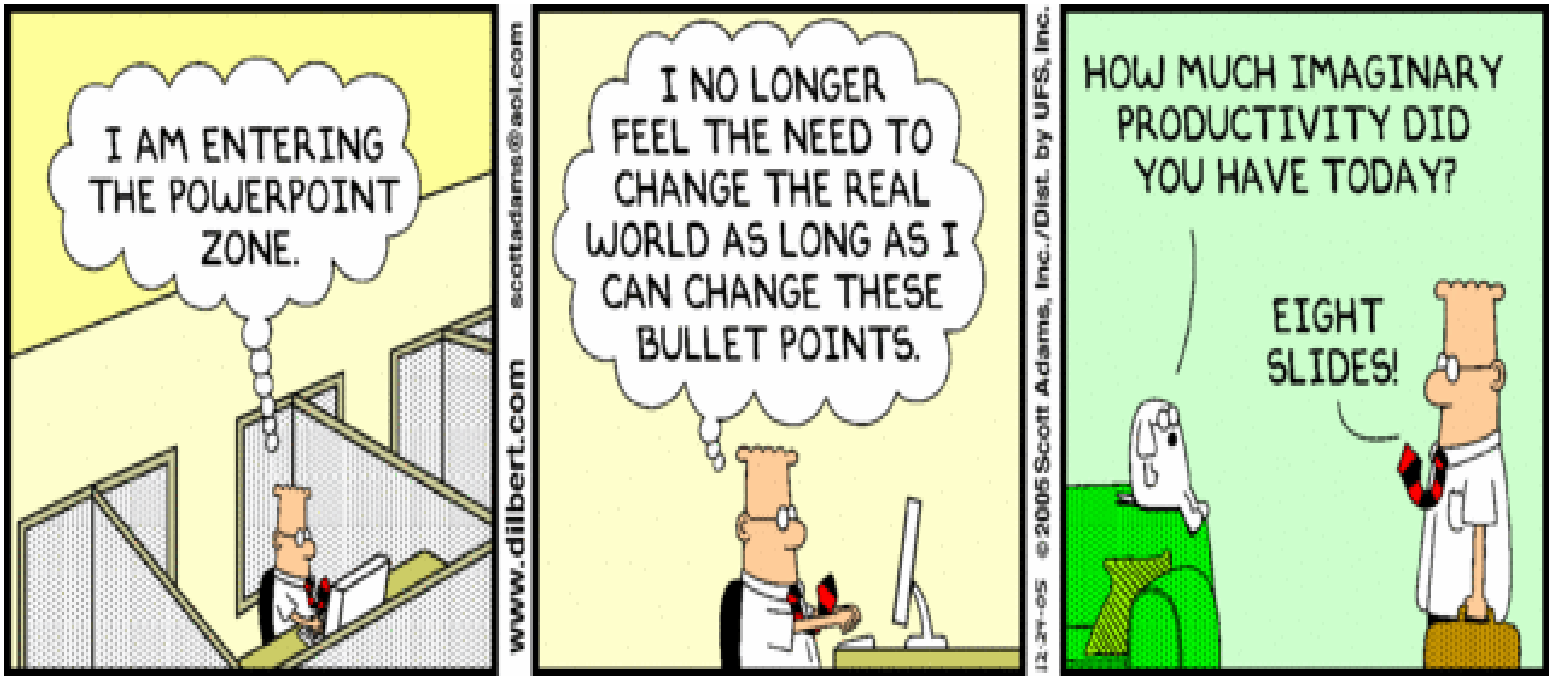
Tammie R. Jones, DNP, MS, RN, CENP

Formerly CNO – St. Mary Medical Center

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.
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I NO LONGER FEEL THE NEED TO CHANGE THE REAL WORLD AS LONG AS I CAN CHANGE THESE BULLET POINTS.
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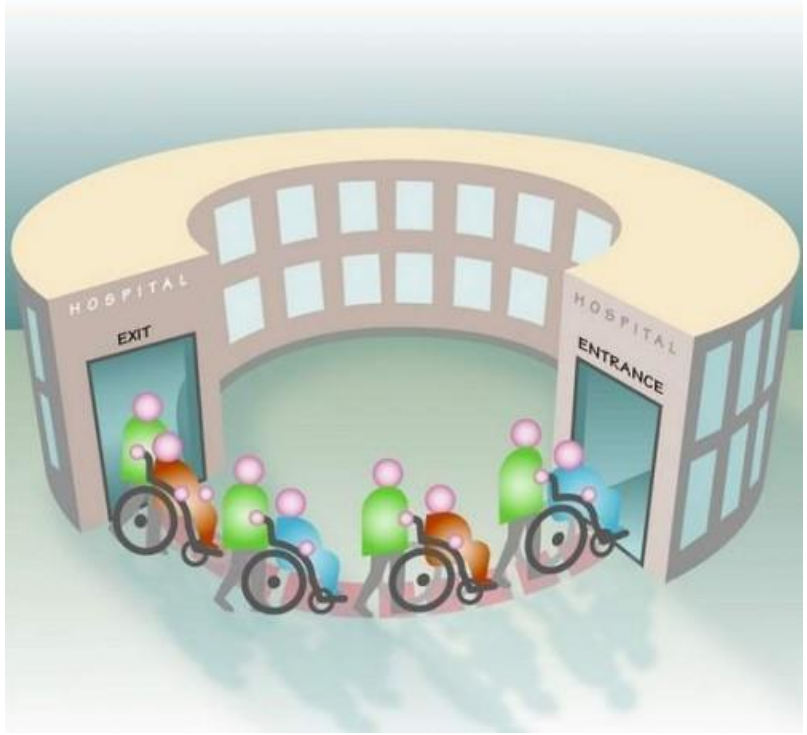
HOW MUCH IMAGINARY PRODUCTIVITY DID YOU HAVE TODAY?
EIGHT SLIDES!

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

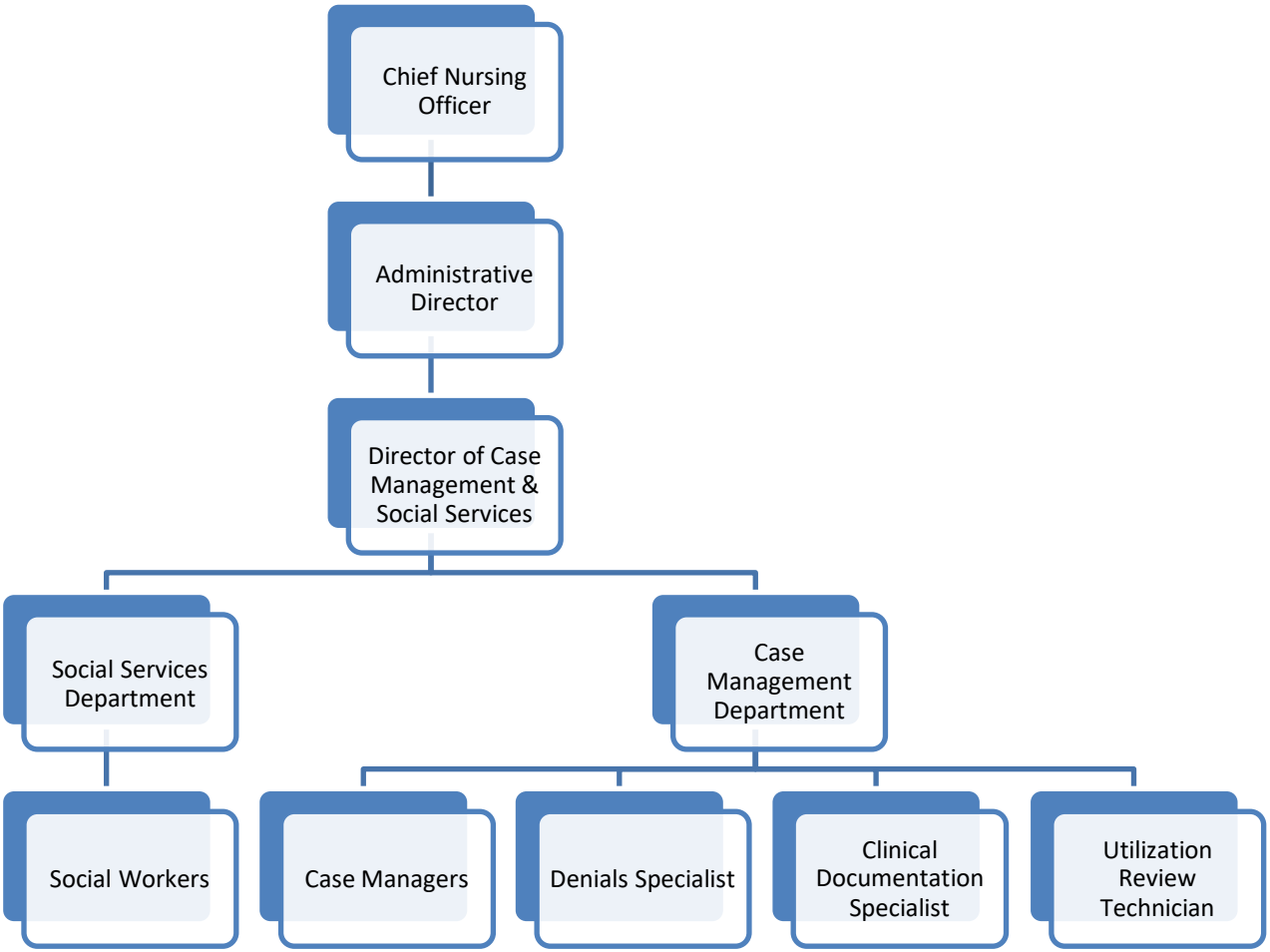
Community Healthcare System®

Readmission Reduction Program



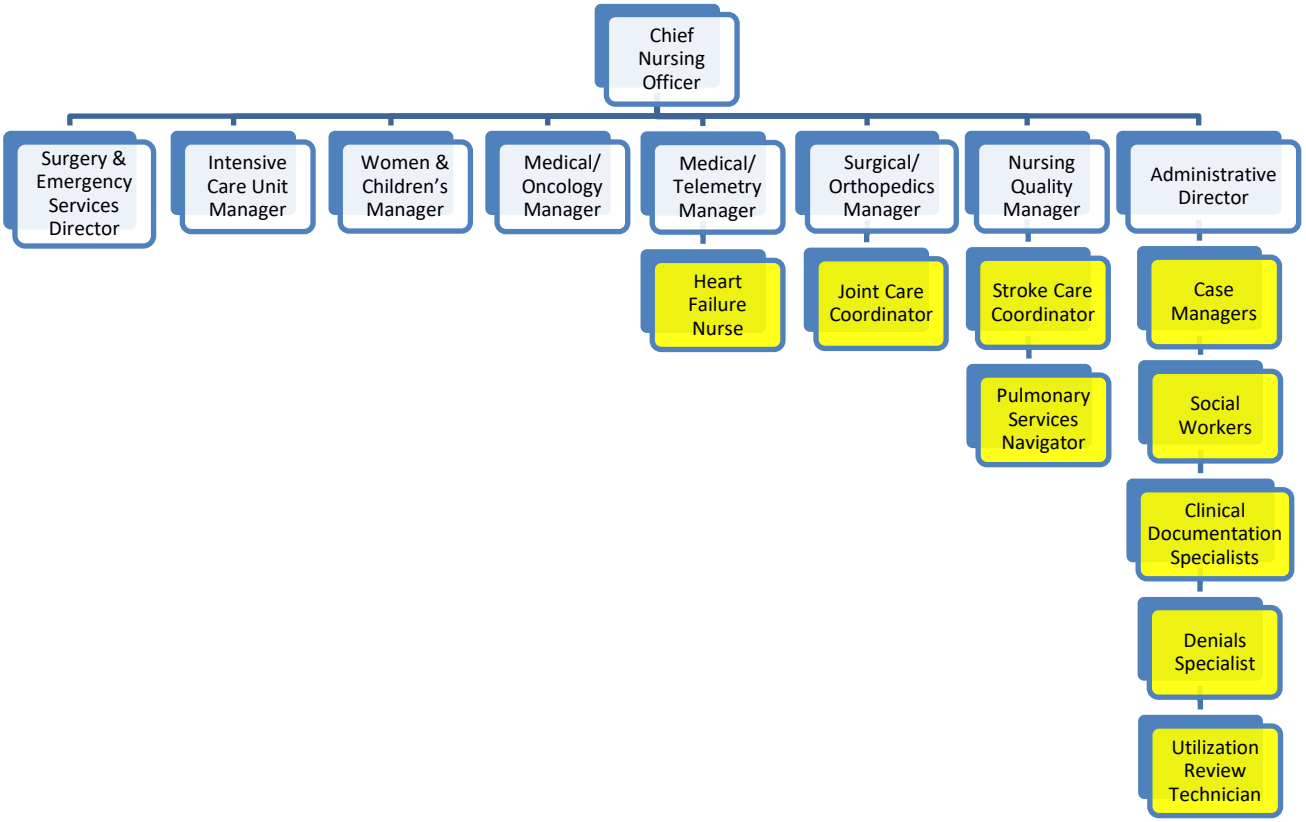
- In 2010, Centers for Medicare and Medicaid Services (CMS) implemented the Readmissions Reduction Program as part of the Affordable Care Act.
- Hospitals financially penalized for readmissions within 30 days of discharge
- Three percent of a hospital's Medicare reimbursement can be withheld based on 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?

⇧ **LOS**

⇩ **CMI**

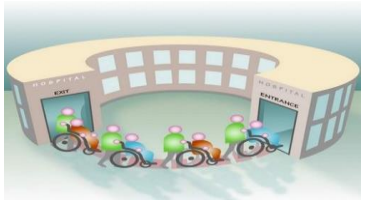
Inefficient/Ineffective Case Management & Social Services

- 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

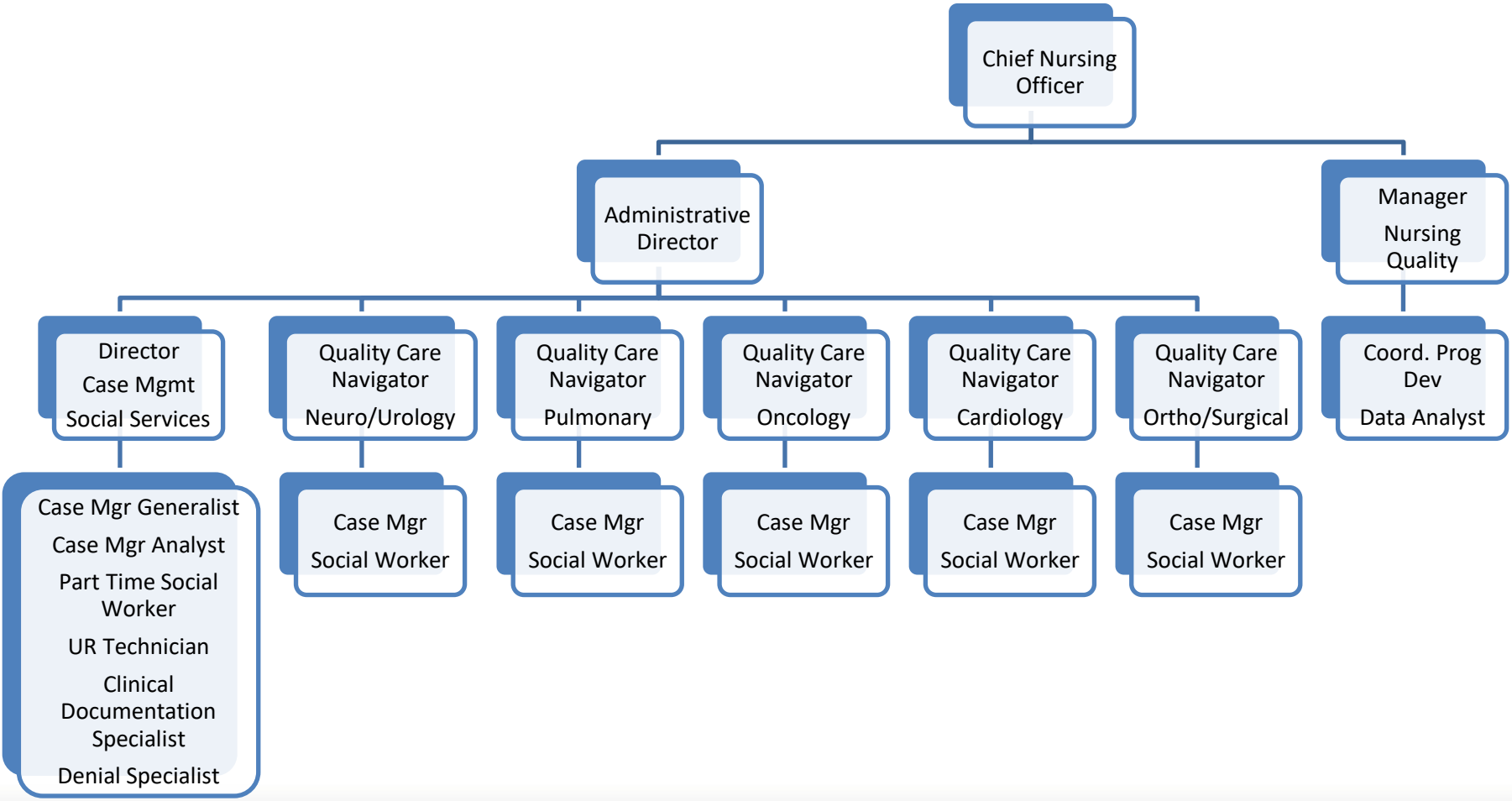


To develop and implement a structure to support quality, cost effective care coordination by:

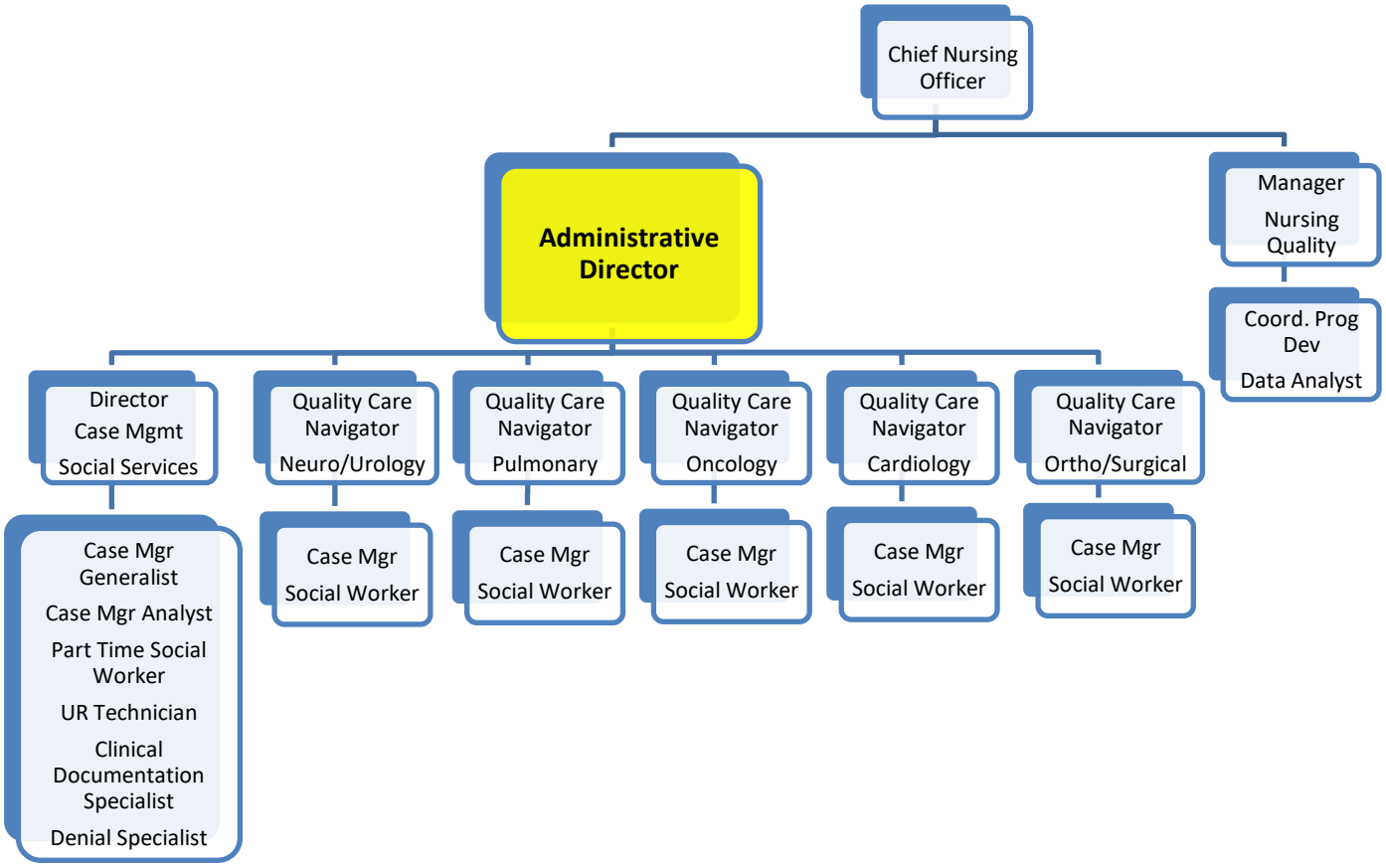
- Minimizing 30 day readmission rates
- Reducing length of stay consistent with national and regional benchmarks
- Enhancing patient perception of care
- Coordinating care across the continuum

Organizational Structure

Quality Care Coordination Department

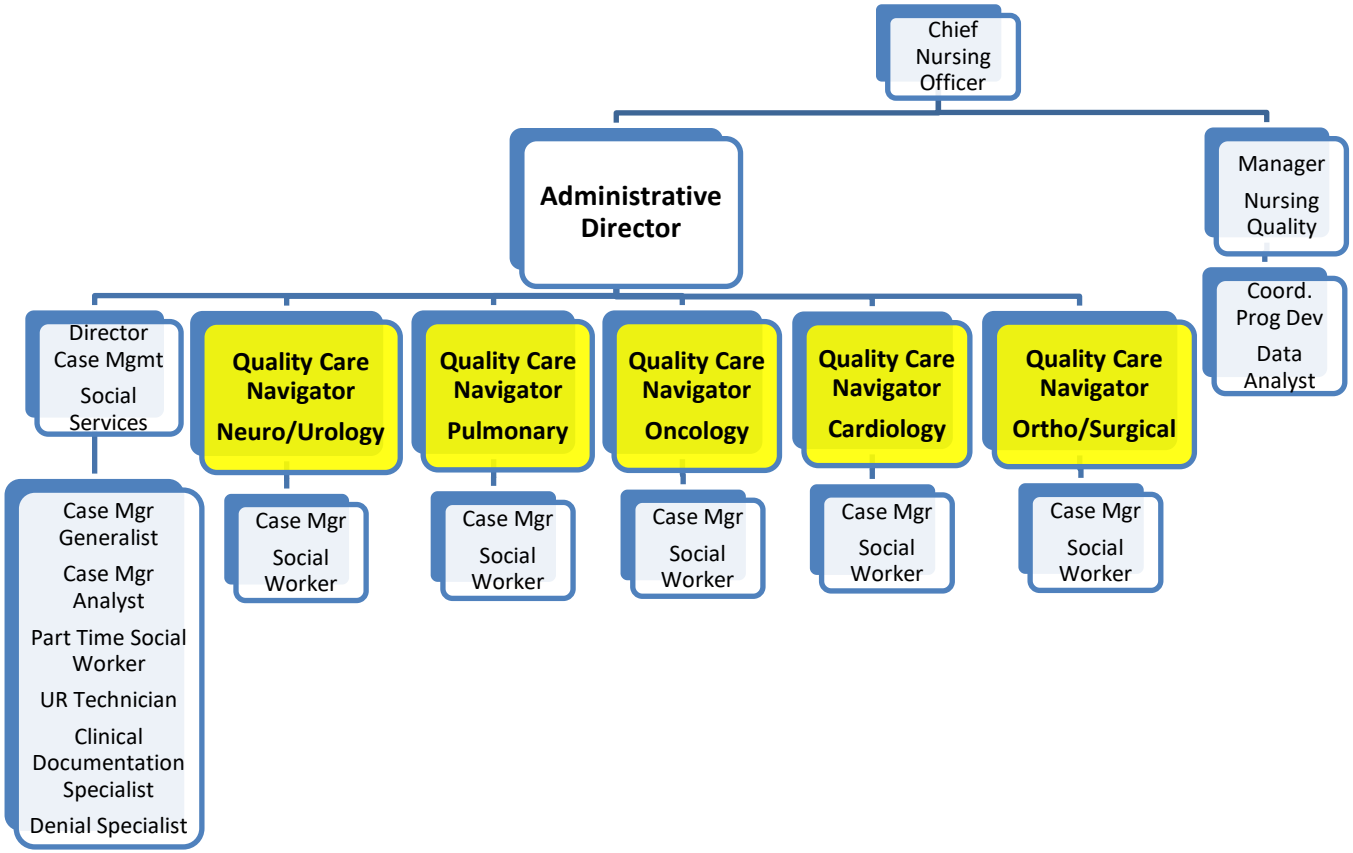


Administrative Director Role



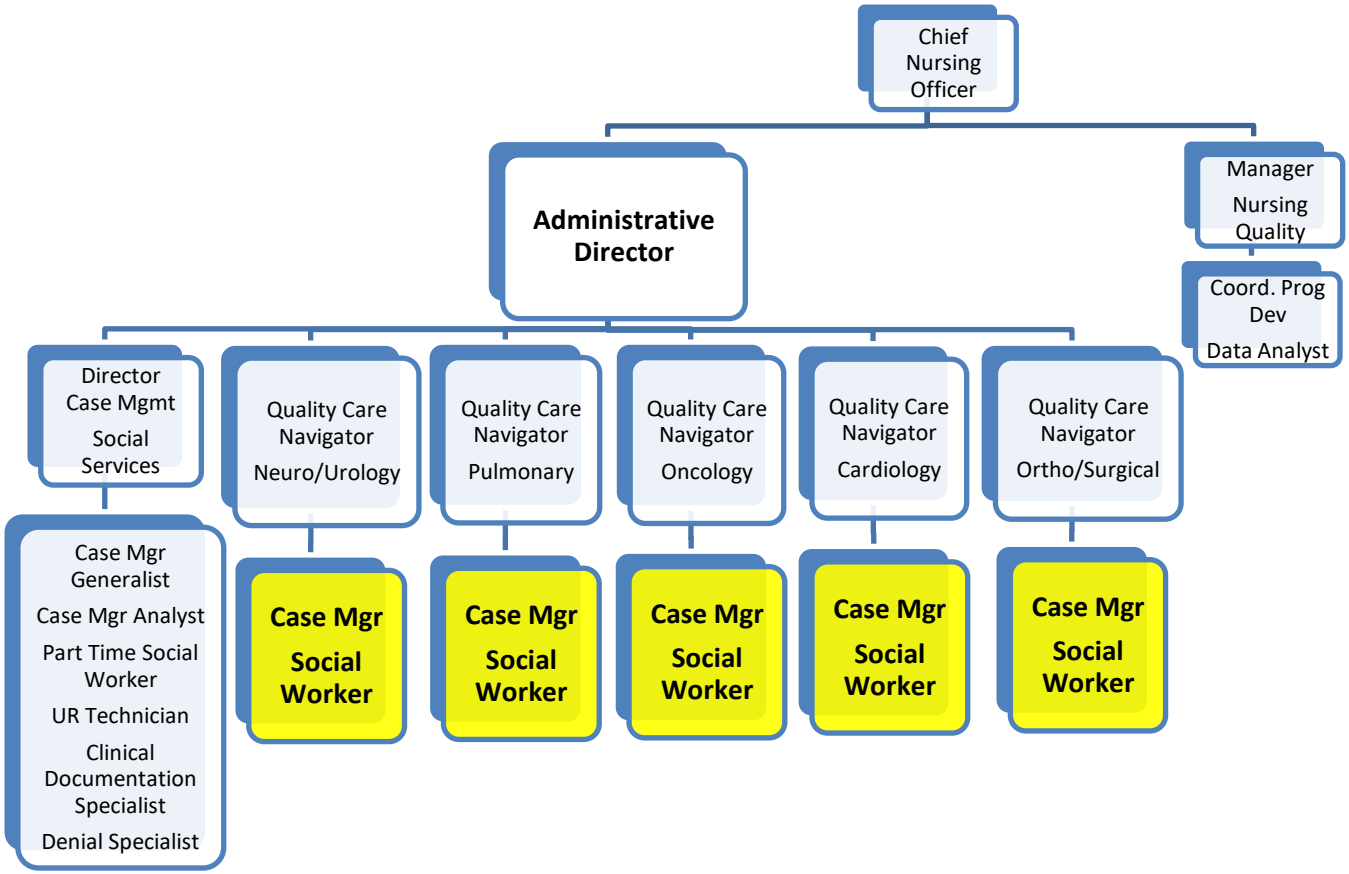
- Leader of quality care coordination department
- Ensures model integrity
  - Operations consistent with new department goals
- Coordinates efforts between
  - Care management
  - Denials management
  - Clinical documentation improvement

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



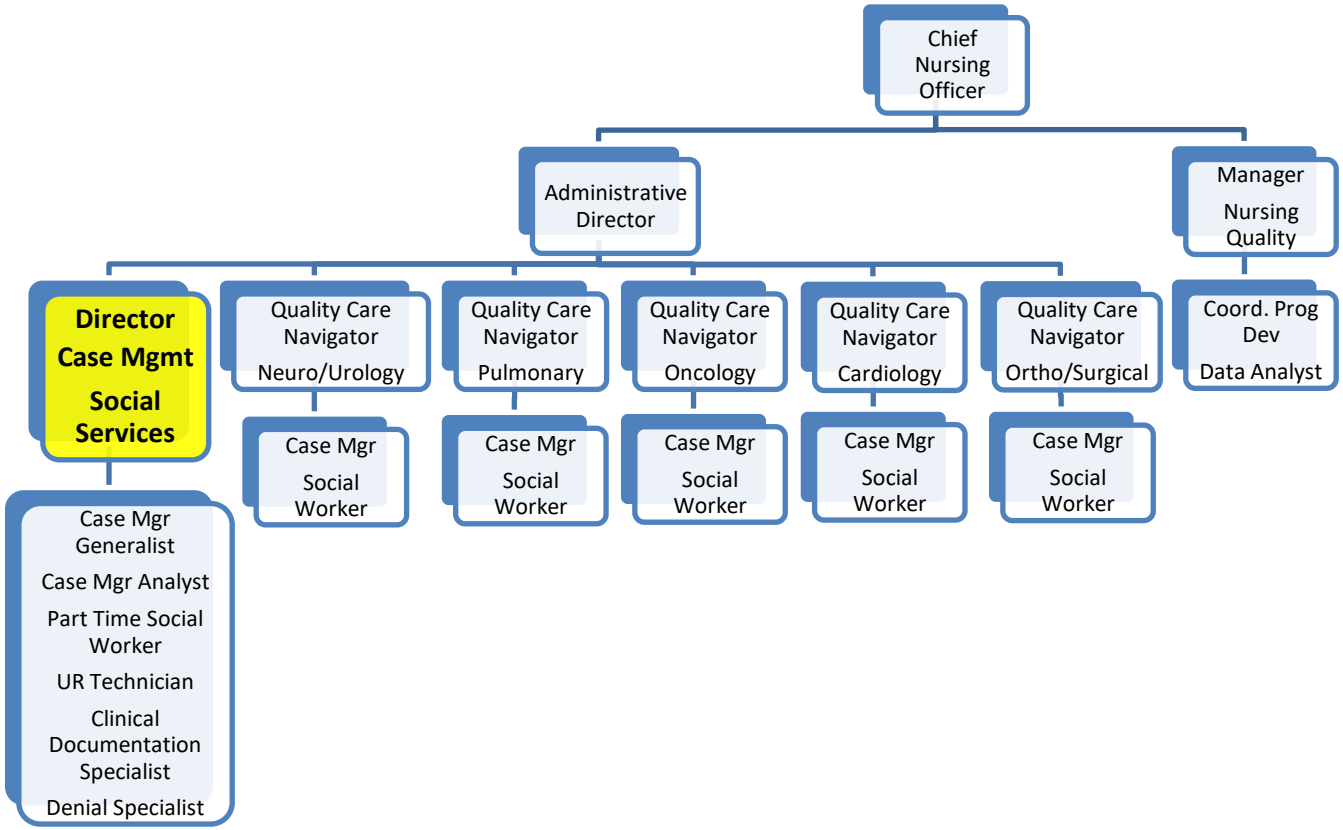
Case Manager

- Focuses on reducing length of stay

Social Worker

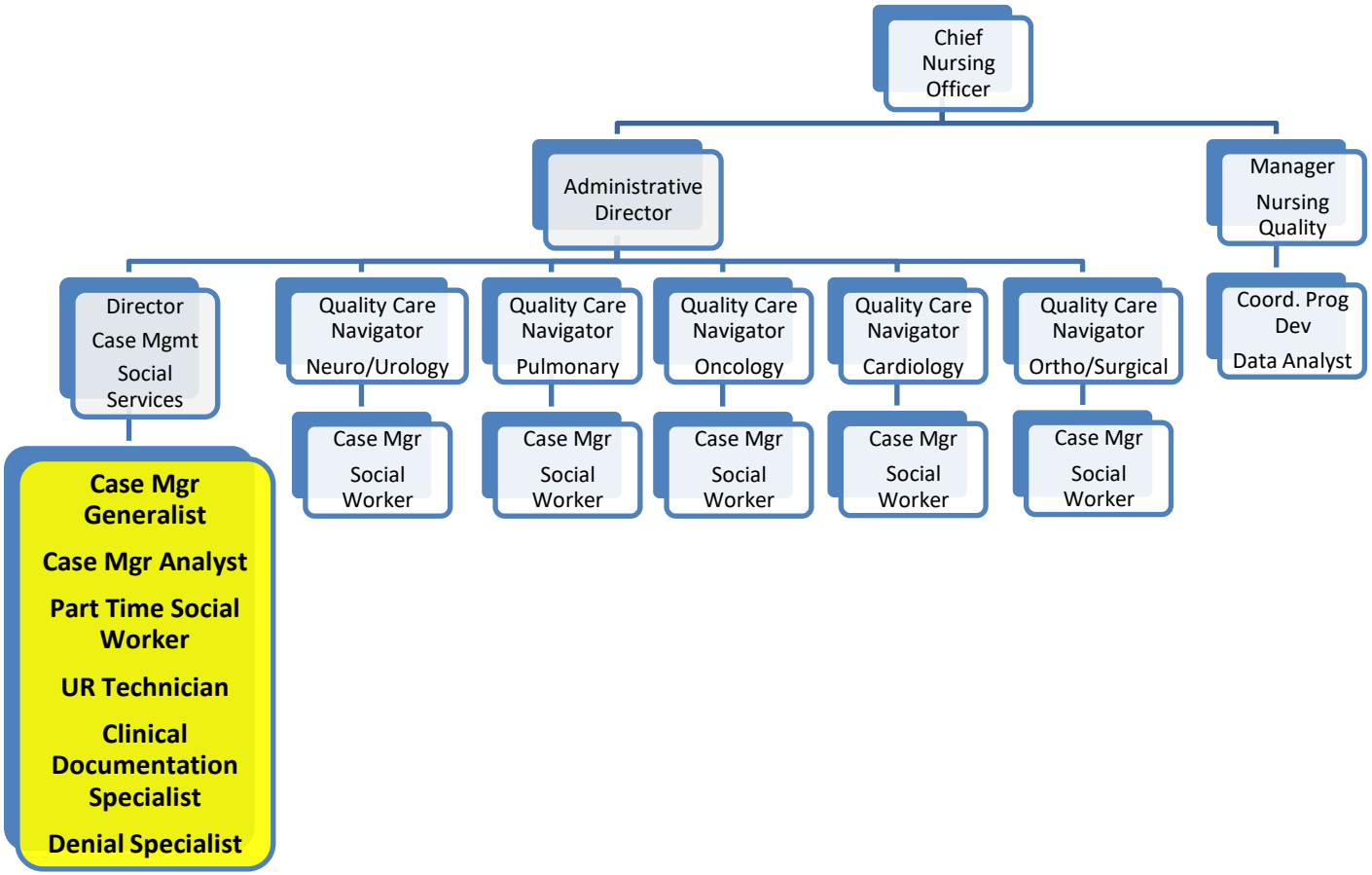
- Focuses on discharge planning
- Both roles report directly to the quality care navigator

Director Case Management & Social Services Role



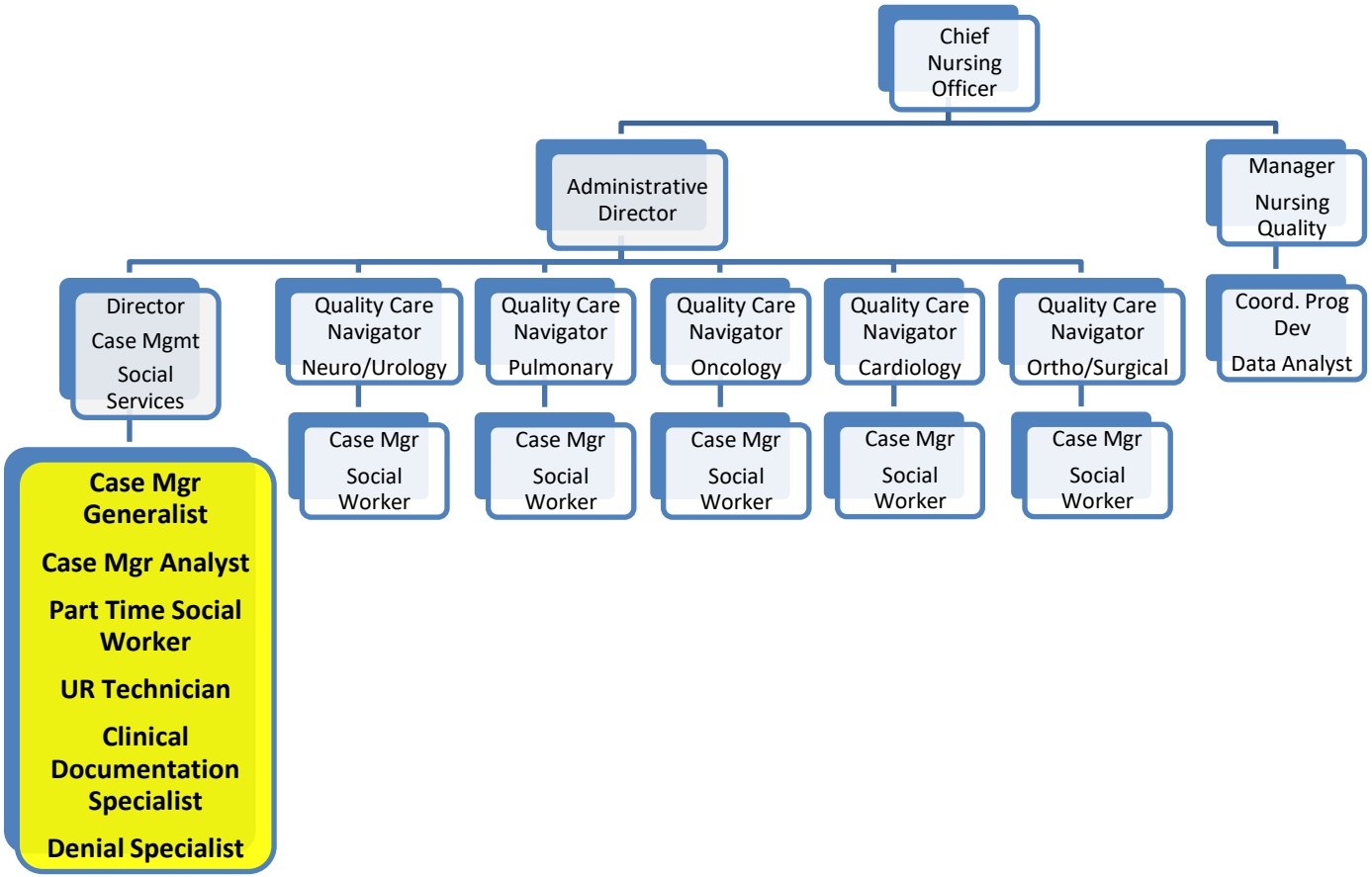
- Leadership responsibility for traditional case management/utilization review activities
  - Regulatory audits
  - Denials activities
  - Clinical documentation improvement
- Keeps abreast of impending regulations
- Communicates and recommends operational changes based on regulations
- Supervision of:
  - Case manager generalist
  - Case manager analyst
  - Part time social worker
  - Denials & clinical documentation specialist
  - Utilization review technician

Case Manager Generalist Role



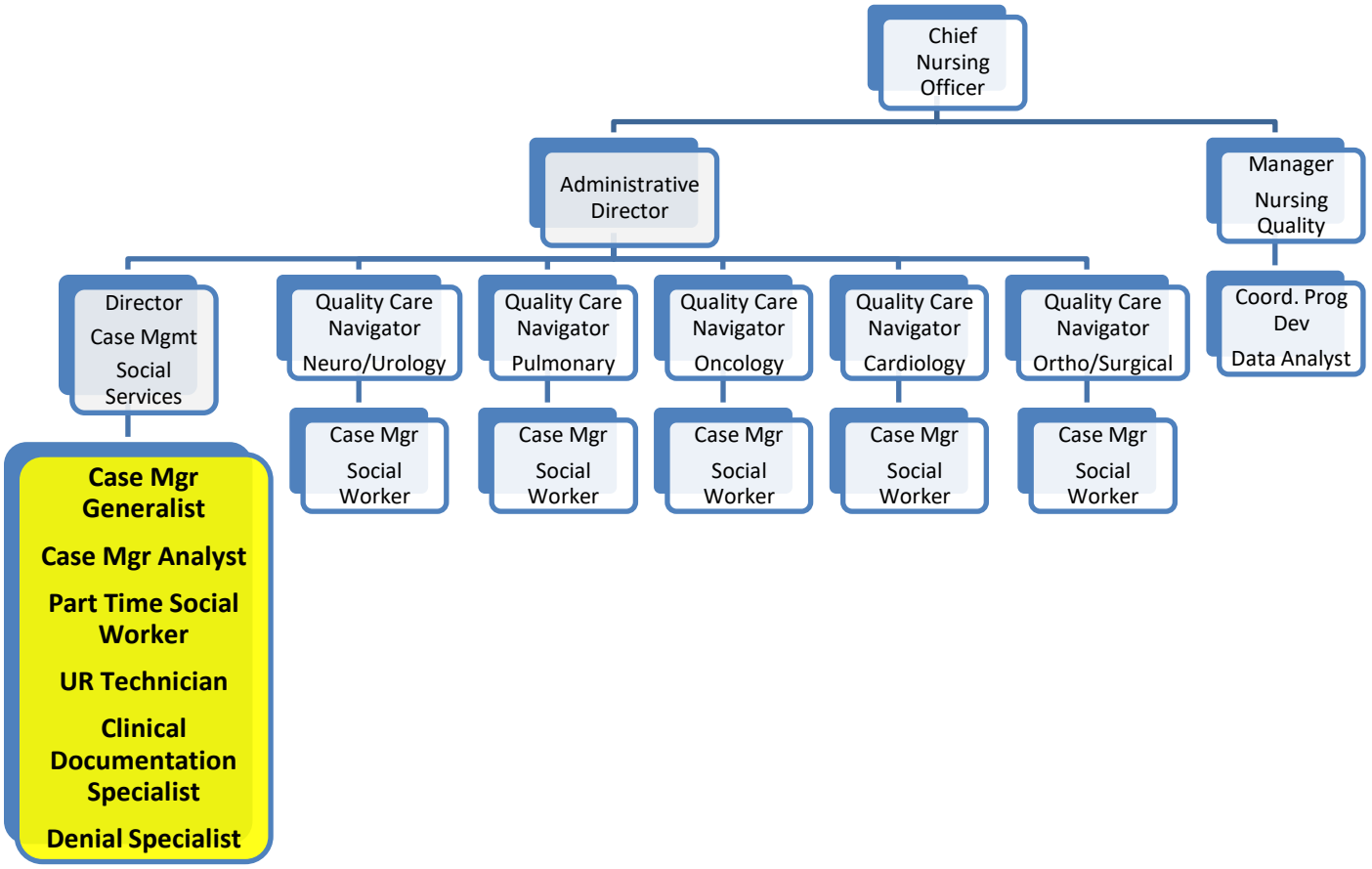
- Provides care management for patients without a concrete diagnosis upon admission

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



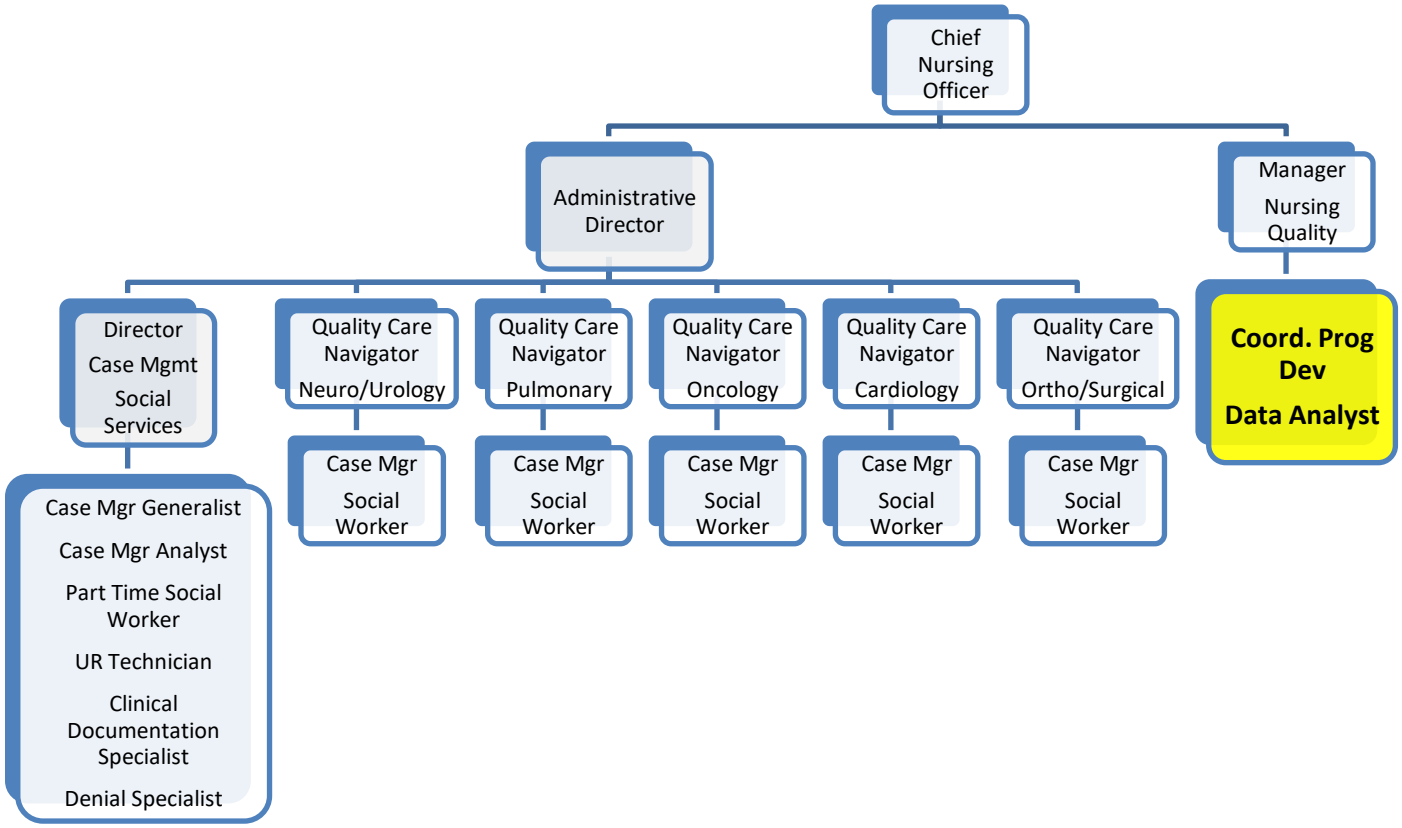
Part Time Social Worker

- 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

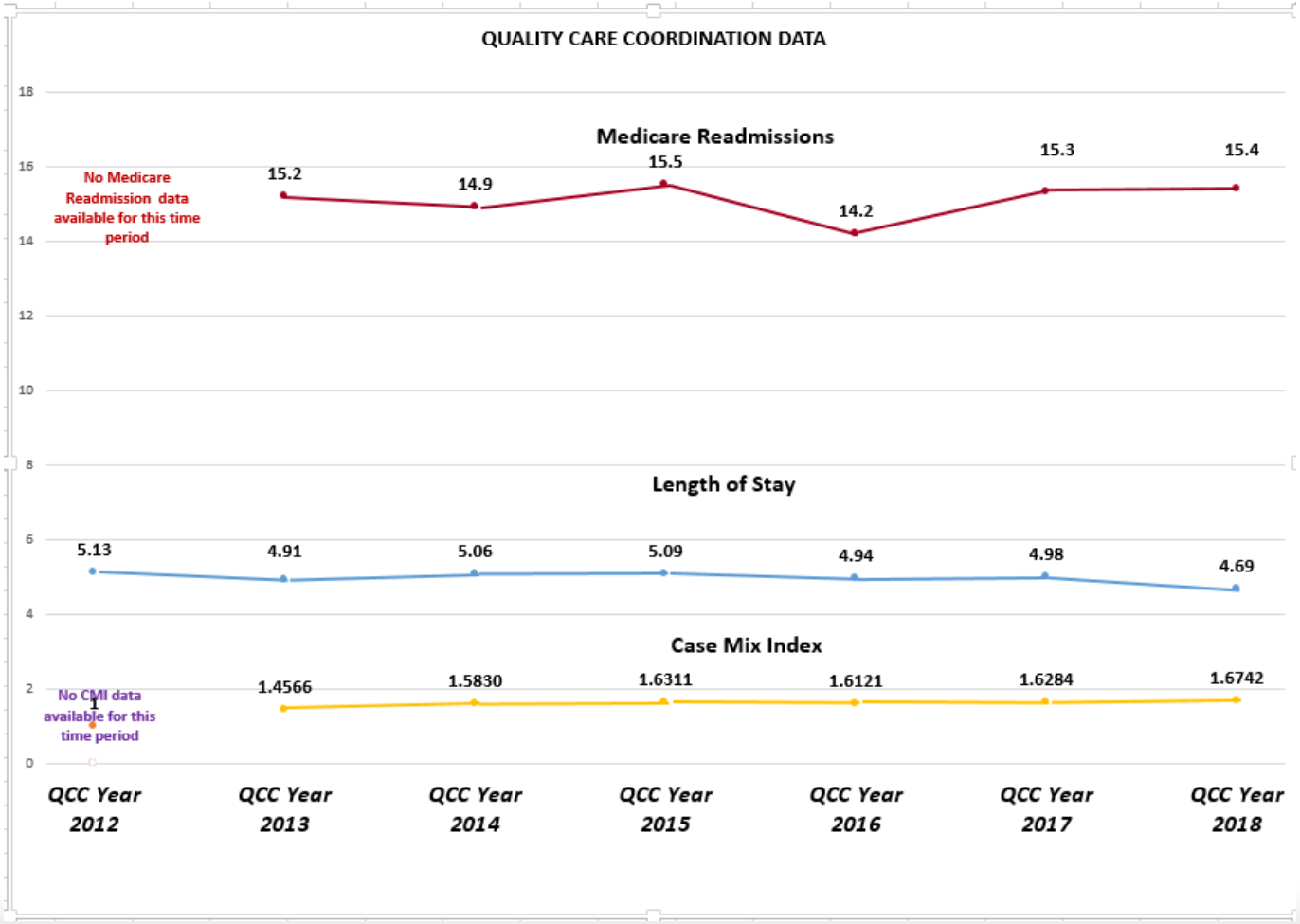
Data Analyst

- 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

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

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

Retrofitting Model

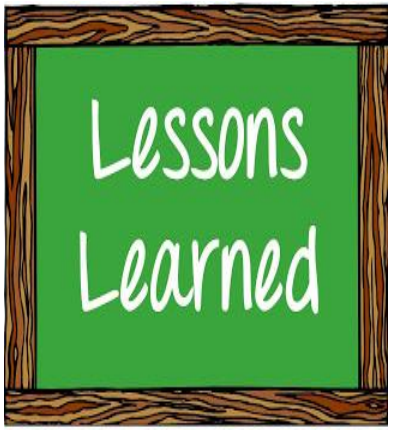
- End of 2014 into 2015 - Dramatic staff turnover
  - This isn't your mother's case management model
  - Quality care navigator (QCN) role a unique position
    - Leadership skills
    - Clinical expert
    - Patient advocate
    - Excellent communicator
  - Many QCNs had clinical expertise but were 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

Not all encompassing

- 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

Lessons Learned



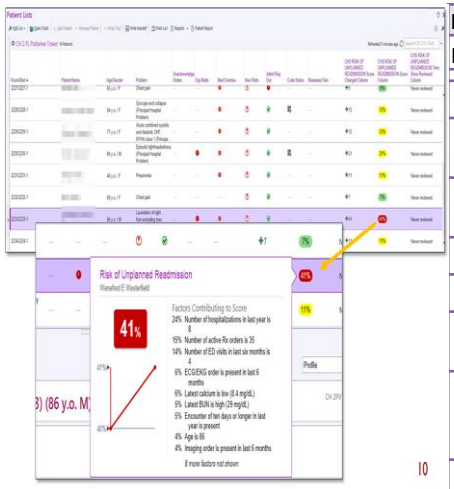
- **Unsuccessful in meeting readmission outcomes**
- **Eighteen percent increase in readmissions for 2016 vs 2015**
- **Assignment of patients by disease sites resulted in higher acuity/readmission potential for some teams**
- **Analysis of readmission patterns was performed**
- **QCN assignments were modified:**
  - Ortho/Surgical
  - Oncology / GI
  - Neuro/Spine / A-Fib
  - Low Risk Medically Complex
  - Moderate Risk Medically Complex
  - High Risk Medically Complex
  - 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

Current Organizational Chart

Lessons Learned

Data is Essential

- 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



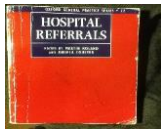
Patient Scoring	
Readmission Score:	66
Male Patient	3
LACE+ URGENT ADMISSION	15
LACE+ DISCHARGE INSTITUTION	-1
Length of Stay	2
LACE+ ALC STATUS	0
ED Visits in Previous 6 Months	3
LACE+ NUMBER OF ELECTIVE ADMISSIONS IN PREVIOUS YEAR	6
LACE+ NUMBER OF URGENT ADMISSIONS IN PREVIOUS YEAR	38

Lessons Learned

Not all encompassing

- 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

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

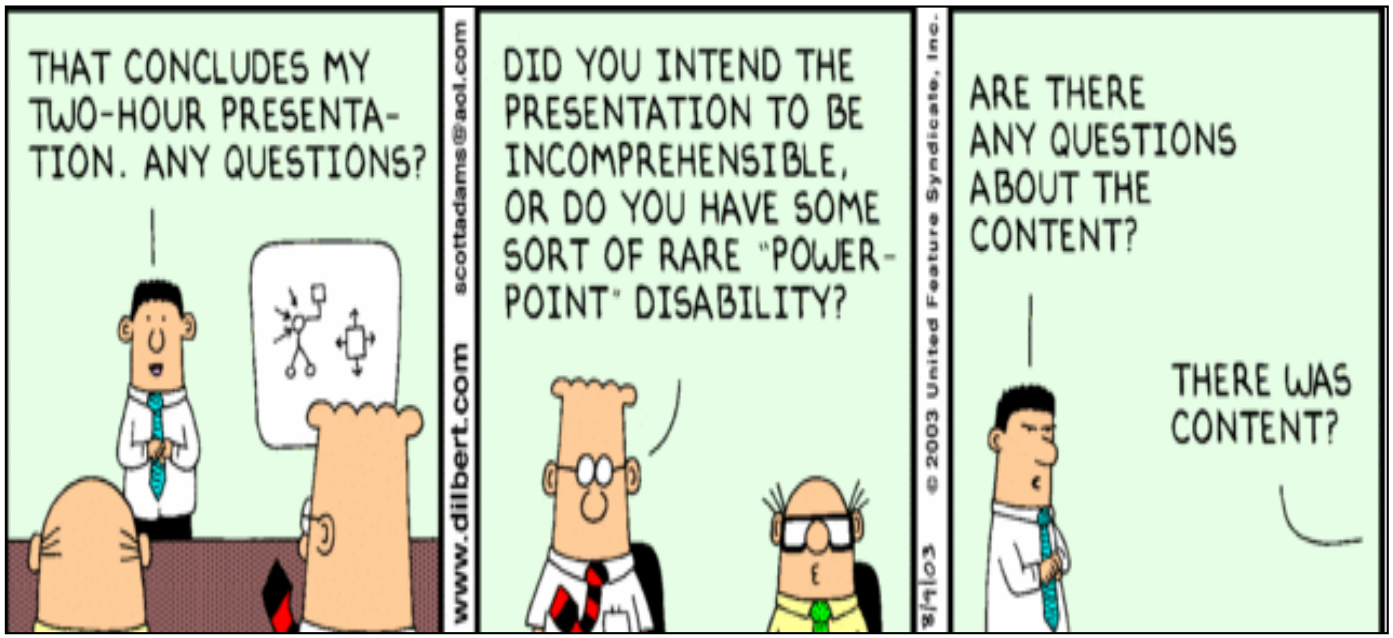
Performance Scorecard YTD

FY 2018

	METRIC	July17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18	April 18	May 18	June 18	YTD	Annual Target
Operational Indicators	Volume														
	Eligible Patients	45	46	64	57	54	65	79	52	94	67	78	55	756	**
	Enrolled in Program	41	44	53	52	54	65	57	46	64	65	44	50	635	**
														84%	50%
	Active Enrolled	30	31	33	27	23	34	38	36	32	29	28	27	368	
	Number of Visits	101	129	114	120	86	112	116	75	87	84	47	72	1143	
	30 Day Readmission Rates														
	Medicare 65 ≥CHF	23.1%	14.3%	15.0%	14.8%	9.5%	31.8%	22.2%	17.6%	23.4%	18.5%	20.8%	12.5%	18.2%	≤21.3
		3/13	2/14	3/20	4/27	2/21	7/22	5/25	2/12	5/27	5/24	6/29	3/24	47/258	
	ALL CHF	18.5%	17.2%	11.4%	15.9%	11.8%	22.0%	21.3%	20.0%	21.1%	24.1%	20.4%	16.7%	18.7%	≤21.3
		5/27	5/29	5/44	7/44	4/34	9/41	10/47	6/30	12/57	13/54	10/49	7/42	93/498	
	Medicare 65 ≥ COPD	23.5%	0.0%	18.8%	9.1%	40.0%	25.0%	11.8%	16.7%	5.6%	36.4%	26.7%	18.2%	18.4%	≤19.2
		4/17	0/14	3/16	1/11	4/10	3/12	2/17	1/6	1/18	4/11	4/15	2/11	29/158	
	ALL COPD	29.5%	2.7%	18.6%	21.1%	22.9%	26.5%	16.2%	21.4%	14.3%	14.7%	24.4%	14.3%	19.1%	≤19.2
		13/44	1/37	8/43	8/38	8/35	9/34	6/37	6/28	5/35	5/34	10/41	4/28	83/434	
	Graduated from Program (30 days)	29	35	41	40	45	52	44	38	50	55	36	45	510	

QCN Model Outcomes

Outcomes	GOAL FY19	Overall	MC-1 (PN/CHF/ COPD/AMI)	MC-2	MC-3	Cardio-vascular (CABG)	Oncology	Ortho (HIP/ KNEE)	Neuro (STROKE)	Unassigned
Nat'l Benchmark	15.3	15.3	16.9 PN 21.6 CHF 19.8 COPD 16.3 AMI			13.8		4.4	12.2	
Hospital Compare	16.9	16.9	18.6 PN 24.3 CHF 22.5 COPD 16.4 AMI			13.5		4.9	15.9	
Medicare Only Readmit % *	≤ 15.0	NA (15.0)	NA (19.7)	NA (17.1)	NA (6.1)	NA (10.3)	NA (17.7)	NA (7.8)	NA (9.5)	NA (8.1)
Team Readmit %	≤ 13.7	NA (13.7)	NA (17.7)	NA (15.3)	NA (4.7)	NA (13.4)	NA (16.3)	NA (7.1)	NA (10.9)	
Sepsis Readmit %	≤ 12.5	NA	NA	NA	NA	NA	NA	NA	NA	NA
ED Visit % *		3.38	0.12 (CHF) 1.49 (COPD)	0.86 (Diab) 0.63 (RF)					0.27 (Stroke)	
LOS *	≤ 4.75	4.54	5.93	4.87	3.29	6.16	4.72	3.77	3.80	1.22
CMI *	≥ 1.6800	1.6189	1.6708	1.7664	1.0501	3.3374	1.2485	2.0721	1.5975	1.1522
Nurses Kept You Informed	≥ 82	80.1	80.1	80.1	80.1	80.1	80.1	80.1	80.1	80.1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THERE WAS CONTENT?

QUESTIONS?