November 9, 2016

Interdisciplinary Rounding to Improve Case Management Outcomes

Toni Cesta, Ph.D., RN FAAN
Partner and Consultant
Case Management Concepts, LLC
East Coast Office
North Bellmore, New York

Beverly Cunningham, MS, RN
Partner and Consultant
Case Management Concepts, LLC
Midwest Office
Grove, OK

Faculty

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care" and her newest book: "Core Skills for Hospital Case Managers".

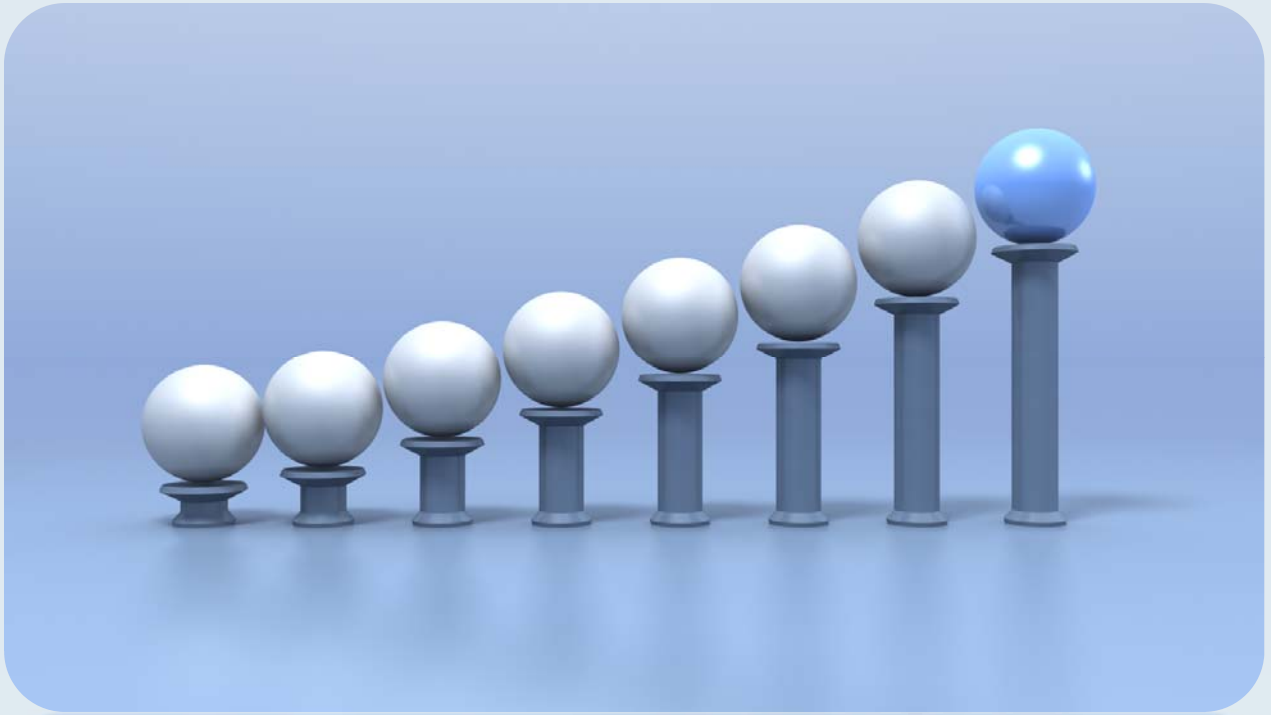
Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

OBJECTIVES

- Item 1: Identify expected outcomes for your rounding process.
- Item 2: Develop effective documentation of rounding processes.
- Item 3: Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC, DNV and the federal government.
- Item 4: Evaluate case management protocols and penalties.



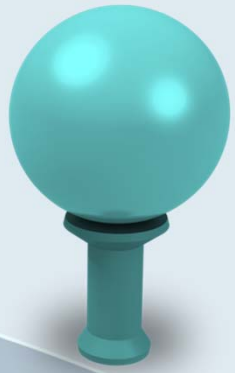
Joint Commission National Patient Safety Goal 2: Improve the Effectiveness of Communication Among Caregivers

STANDARDIZED HAND OFF PROTOCOLS

- Communication of information that can can take place through a number of modalities
- Can include a written or verbal component

EFFECTIVE CASE MANAGEMENT TEAMS REQUIRE EXCELLENT COMMUNICATION

- Vertical Communication
  - Director or Manager
  - Physician Advisor
  - Case Management Extender



- Horizontal Communication
  - Nursing
  - Attending Physician
  - Hospitalist
  - Radiology
  - Laboratory
  - Pharmacy

CRUCIAL CONVERSATIONS

- Case Management Department Hand-Offs:
  - Between case managers and social workers
  - Between case management department staff and next level of care providers
  - Between nursing unit managers and staff
  - During daily huddles: case manager, nurses, ancillary services

IMPLEMENTATION EXPECTATIONS FOR EFFECTIVE HAND-OFFS

1. Interactive communication allowing for the opportunity for questioning between the giver and receiver of patient information.
2. Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.
3. A process for verification of the received information, including repeat-back or read-back, as appropriate.

IMPLEMENTATION EXPECTATIONS FOR EFFECTIVE HAND-OFFS

4. An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment and services.
5. Interruptions during hand-offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

CHANGE OF SHIFT ROUNDS – DEPT. OF NURSING

- Traditional interchange of clinical information during shift change
- Between staff nurses
- Deals with bedside care, assessments and outcomes
- Should not take place during interdisciplinary care rounds

TEACHING ROUNDS – DEPARTMENT OF MEDICINE

- Used in teaching hospitals
- Opportunity for attending physician or hospitalist to lead in-depth discussion of patient's clinical state, achievement of goals and expected outcomes
- Should not take place during interdisciplinary care rounds

PATIENT CARE CONFERENCES

- Used as an adjunct to walking rounds
- Used when additional information needs to be discussed or shared
- Provides opportunity for team to have more in-depth discussion of issues such as:
  - End-of-life
  - Family barriers
  - Other discharge delay issues
- May include family members or family care givers

HUDDLES

- Shortened version of patient care rounds
- Typically done in the afternoon as a follow-up to the full rounds done in the morning
- Can be scheduled or impromptu
- Usually attended by staff RN, case manager and physician

PLANNING FOR HUDDLES

- Best if scheduled at the same time each day
- Allows for each huddle member to be prepared with outcomes, questions, concerns
- Does not need to include every patient
- Should include those patients with outstanding issues identified during full rounds in the morning

INTERNAL PATIENT TRANSFERS

- Should include hard and soft handoff
- Soft handoff includes written summary and other needed documentation
- Hard handoff includes verbal information exchange in addition to written materials

DISCHARGE & INTER-FACILITY TRANSFERS

- Conducted by physician and case management staff depending on type of inter-facility transfer
  - Nursing home – case management and physician
  - Home care – case management
  - Acute care – physician and staff nurse, possibly case management

- For discharge
  - Physician to notify primary care provider
  - Case management to work with family and/or family caregiver
  - Family members to be given written and oral instructions

INTERDISCIPLINARY ROUNDS

- A key care coordination strategy
- A real-time in-person exchange of information
- Makes the goals and plan of care for each patient clear to all members of the team
- A formal and organized approach to patient care
- Ensures that the patient/family receive consistent and accurate information
- Increases the efficiency and safety of patient care

ENCOURAGED BY THE INSTITUTE OF MEDICINE

- As a mechanism for interdisciplinary collaboration
- Decision support at the patient care level
- Evidence-based management processes

WHY WALKING ROUNDS?

- Enables all members of the team caring for the patient to offer individual expertise and contribute to patient care
- Disciplines come together to coordinate care
- Improves communication among and between team members
- Considered best practice by the Institute for Healthcare Improvement (IHI) and The Joint Commission

SURVEY OF ROUNDS

Patients and nurses were surveyed to see if they were satisfied with the rounding process. *Patient comments were positive:*

1. “I didn’t realize there were so many people involved in my care”.
2. “I have an opportunity to ask questions”.
3. “I actually got to talk to my doctor”.

Nurses commented with some mixed reviews:

1. Nurses are better informed about the daily plan of care from all disciplines.
2. The nurse hears what the physician tells the patient.
3. Calls from nurses to physicians have decreased.
4. The rounds were time-consuming for the nurse.

Catawba Valley Medical Center, SC, 2011

STANDARDIZED WORK PARADIGM

I know you'll be able to figure it out. Just get it done the best way you can.

In order to have consistent results we must do things the same way every time.

WALKING or BEDSIDE PATIENT CARE ROUNDS

- Critical to patient flow
- Is not report
- Should focus on
  - In-patient plan of care
  - Expected outcomes of care
  - Barriers to care
  - Transitions in hospital (one level of care to the next)
  - Discharge

- Hospitalists typically lead multidisciplinary teams
- In hospitals without hospitalists, for example, or when a hospitalist just starting out defers to a nurse leader—where it makes sense for nurses or case managers to take the lead.
- The consensus is that mornings, either before or after new admissions have been processed, seem to work best. That way, discharges can be handled after rounds

The Daily Hospitalist - 2008

A DAILY GAME PLAN

ROUNDS FOCUS – COORDINATION OF CARE

- Coordinate care among disciplines
- Review the patient's current status
- Clarify patient goals and desired outcomes
- Create a comprehensive plan of care

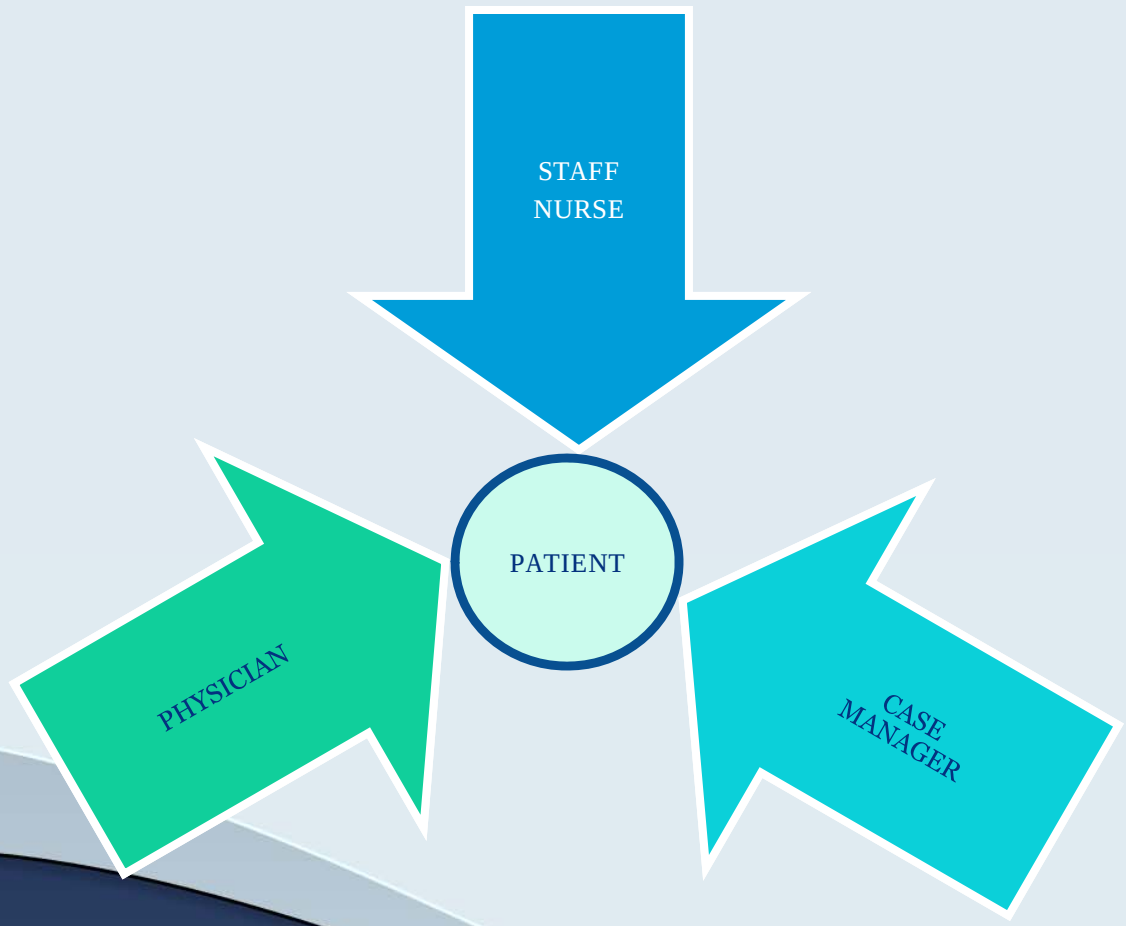
ROUNDS FOCUS – COMMUNICATION

- Identification of safety risks
- Identification of daily goals
- Patient education
- A consistent approach by all team members

KEY COMPONENTS TO CONSIDER WHEN DEVELOPING ROUNDS

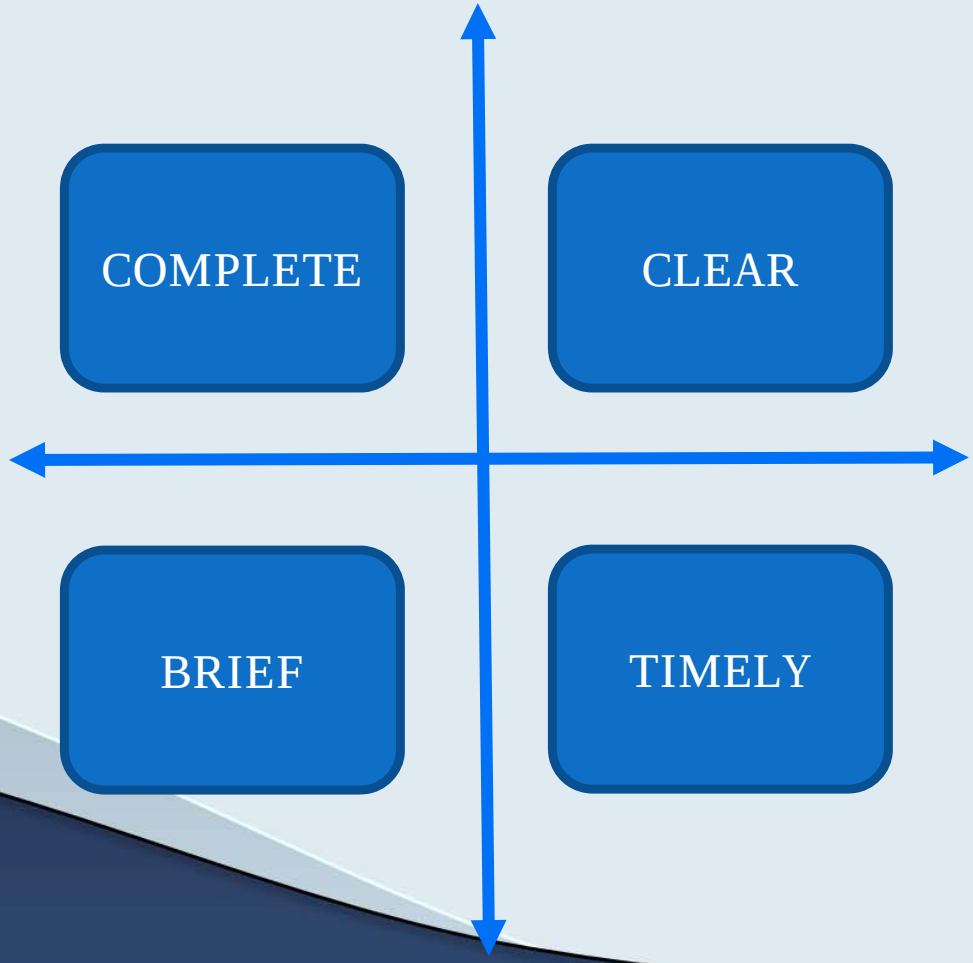
- Identify and refine your goals for rounds
- Create a structure and stick to it
- Leadership is key – identify the leader of rounds
- Pick a standard time for rounds each day
- Engage with the patient and family
- Measure success

KEY MEMBERS OF THE ROUNDING TEAM

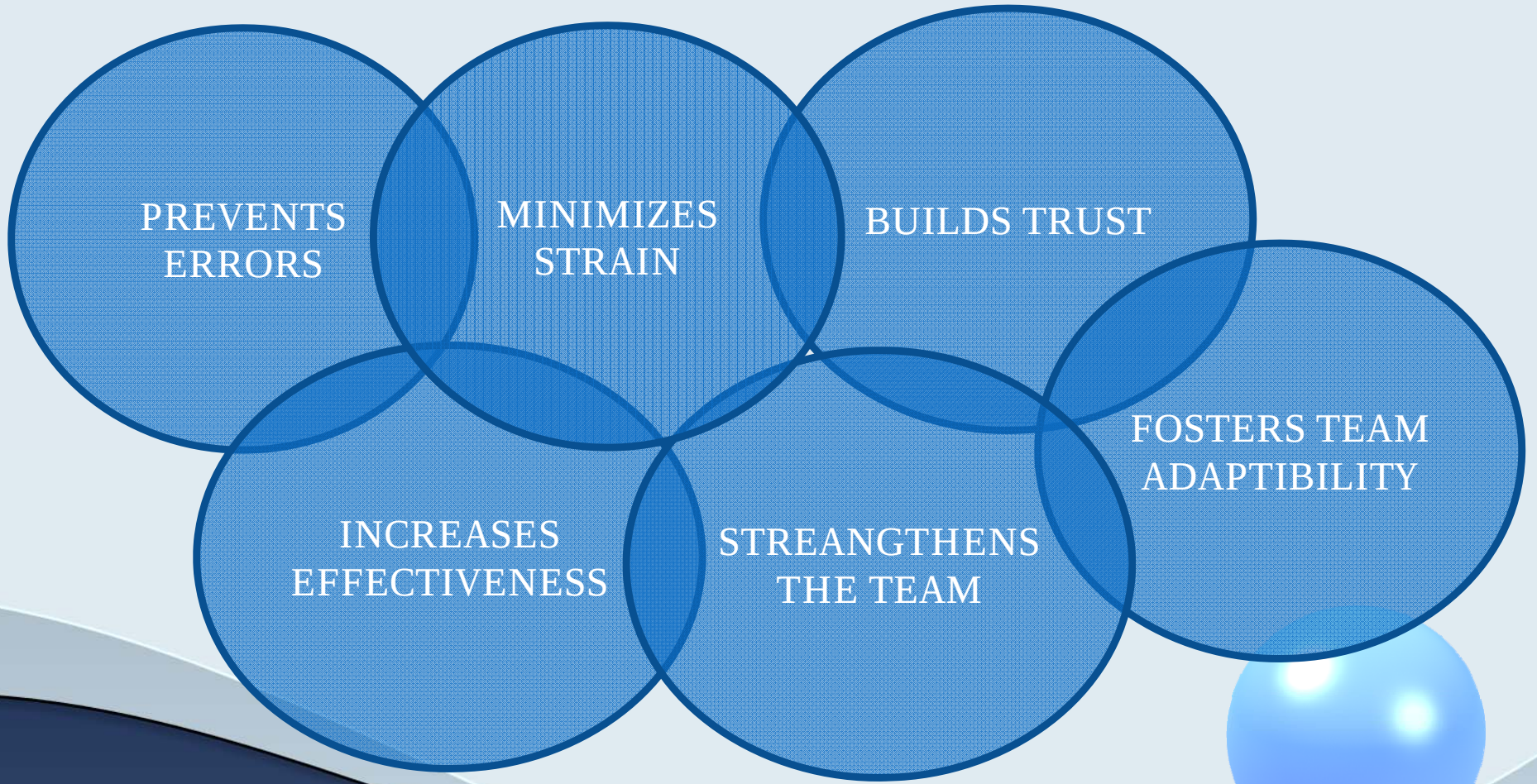


- Minimum staff needed for rounds
- Appropriate staff for huddles

EFFECTIVE COMMUNICATION ON ROUNDS



COMMUNICATION AND TEAMWORK ON ROUNDS



KEY STRUCTURAL POINTS

- Assign leadership
- Select team participants from interdisciplinary team – appropriate to the unit's clinical specialty
- Be sure team members represent all relevant disciplines
- Restate the focus of rounds with the patient each time
- Develop daily care goals

SETTING DAILY GOALS

1. Determine the key goal or goals for the day;

2. Document the goals so that they are readily accessible to the care team and the patient and family;

3. Provide daily feedback on the goals to refine and reset them for the current day.

EXAMPLES OF DAILY GOALS

- Discontinue oxygen by 4 pm

- Wean off vasopressors by midnight

- Mobilize the patient to walk 20 feet

- Initiate hospice referral

STRATEGIES FOR GETTING STARTED

- Leverage existing rounding processes
  - Keep separate from nursing change of shift or teaching rounds
- Seek willing participants
- Start small, test small and often
- Choose one process to focus on at a time

STRATEGIES FOR GETTING STARTED

- Develop and document a daily goal for each patient
- Use a short, simple tool to help guide rounds
- Consider including support staff – Pastoral Care 1- 2 times per week
- Track interventions – get feedback

SEGMENTING ROUNDS

- You may segment populations on units to retain consistency among team members
- Use staff nurse as frame of reference
- If rounding with specialty physicians, focus on those patients with that physician – for example heart failure

ROUNDING WITH HOSPITALISTS

- Rotate nurses so that one joins the rounds to discuss her or his patients, then leaves as another nurse comes in.
- Hospitalists who don't work on a geographic basis with hospitalist-only units also need to rotate in and out, making it critical to be at the meeting place on time.
- Some hospitals have moved toward geographic units for hospitalists to make interdisciplinary rounds easier.
- Even with good planning, putting such rounds into practice requires flexibility.

SCRIPTING

- Standardize key questions
- Write them on the goal sheet or other tool
- Keep academic discussions outside the patient room
- Allow 60 seconds per patient – on the average
- Tell patient you will come back after rounds if he or she has a lot of questions
- Engage support staff for patient requests such as water, tissues, etc.

SCRIPTING

- Problem List
  - Any pertinent past medical history
  - Systems-based list of current problems
  - Any invasive tubes / devices
- Expected tasks to be completed
  - Labs/ radiology and what to do about them
  - Tests to order or follow-up on

SCRIPTING

- Diagnostic one-liner
  - Includes age, sex, relevant past history related to current problem and current chief complaint/reason for hospitalization
- If/Then
  - Frequent issues to be expected with a plan to resolve in if/then format " if HTN, please give Hydralazine"

SCRIPTING

- Demographics
  - Name / Medical record number
  - Room number
  - Admission date
  - Expected length of stay
  - Primary team
  - Code status
  - Family info
  - Insurance information

SCRIPTING

- Therapeutics
  - Medications
  - Focus on IV meds and when they can be transitioned to oral
  - Diet with any weaning orders
  - Oxygen with weaning instructions
  - Progressive ambulation

SCRIPTING

- Results and other important facts
  - Labs
  - Cultures
  - Radiology test results
  - Consults
- Care Coordination
  - Expected against actual length of stay
  - Any patient care barriers
    - Social
    - Insurance

DAILY GOALS

- Determine the key goals for that day
- Document the goals so they are readily accessible to the care team, and the patient and family
- Provide feedback and reflection on the progress toward the goals every day
- Reset the goals as needed

ENGAGE THE PATIENT AND FAMILY IN THE ROUNDING PROCESS

- Invite families to participate – this can be very powerful
- Orient the family to rounds before inviting them include:
  - Focus
  - Routine
  - Expectations

ENGAGE THE PATIENT AND FAMILY

- Post the day and time of rounds in the patient rooms
- When rounds begin – start with a brief introduction to the patient and family
  - Purpose
  - Time
  - Encourage participation

POST A SIGN

ROUNDS TO BE CONDUCTED
IN PATIENT ROOMS AT
9:30 am DAILY.

FAMILY MEMBERS ARE
INVITED TO ATTEND

PROVIDER ROUNDING PROCESS

- Listen to last 24 hour patient update
- Discuss working diagnosis
- Enter any patient orders
- Review preliminary plan for discharge, meds, test

- Sit next to patient
- Introduce team – name and discipline
- Interview patient. Get their story
- Discuss plan of care, test results, next steps, other recommendations
- Answer any questions

- Enter orders, clarify and issues
- Enter progress notes, or dictation
- Call consulting physicians, family regarding test results
- Summarize expectations to team members

RESIDENT ROUNDING PROCESS

- Present patient case to attending physician / team
- Update team on patient conditions
- Give recommendations for plan of care
- Enter any orders, including medications

- Support attending physician during assessment
- Help answer any questions

- Enter orders as needed for patients
- Enter progress notes
- Call consulting physicians as directed by attending
- Discuss med rec with pharmacist

STAFF RN ROUNDING PROCESS

- Review patient progress over past 24 hours
- Focus on any abnormal findings
- Review any patient/family concerns
- Identify any barriers to patient discharge
- Review any issues such as activity, foley, IV, wound vac

- Bring laptop or other device to patient room
- Listen to conversation with patient
- Ask/answer questions from patient and team
- Note orders to be placed later

- Verify orders
- Discus and implement medication monitoring
- Make decisions about any remaining concerns
- Document outcome of rounds

CASE MANAGER ROUNDING PROCESS

- Review admission status – in-patient versus observation
- Review case management admission assessment
- Review initial discharge plan and insurance
- Review expected length of stay and discharge date

- Discuss expected length of stay and discharge day
- Discuss discharge plan – or updated plan – with patient and family
- Identify any additional patient education needs
- Identify any social work triggers for referral to social work

- Clarify next steps based on patient's goals achievement
- Document any changes to discharge plan
- Refer to social work as needed

SOCIAL WORKER ROUNDING PROCESS

- Review case management admission assessment
- Screen patient for psychosocial needs
- Review initial discharge plan
- Review expected length of stay and discharge date

- Discuss expected length of stay and discharge day
- Discuss discharge plan – or updated plan – with patient and family
- If accepting the case review / begin psychosocial assessment

- Clarify next steps based on patient's goals achievement
- Document any changes to discharge plan
- Complete in-depth psychosocial assessment

REGISTERED PHARMACIST ROUNDING PROCESS

- Review daily progress notes
- Review medication profile, medication history and med rec
- Review PRN med use
- Discuss medication concerns and abnormal lab / culture findings

- Listen to conversation
- Ask / answer any patient questions
- Note orders to be placed later

- Verify orders
- Discuss and implement medication monitoring
- Make decisions about any remaining med concerns
- Document progress note

CLINICAL DOCUMENTATION IMPROVEMENT SPECIALIST ROUNDING PROCESS

- Review patient information in medical record
- Listen to overview of patient

- Listen to patient status
- Consider any questions to ask physician

- Clarify and identify any additional diagnoses / conditions – query if needed
- Review physician documentation for accuracy
- Provide any needed physician education

TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

GENERAL INFORMATION REGARDING ROUNDS

- Rounds must occur daily Monday through Friday at a consistent time
- All critical members of the interdisciplinary team are expected to attend
- The physician and nurse manager will facilitate rounds

PROCESS FOR ROUNDS:

Each person participating has talking points

- Physician/nurse should discuss:

- The plan of care
- The expected outcomes of care
- The expected length of stay
- Discharge plan
- Barriers to care

Case manager should discuss:

- Status of discharge plan
- Barriers to care
- Barriers to discharge
- Any reimbursement issues
- The expected length of stay

Social worker should discuss:

- Any psychosocial issues
- Any barriers to discharge

Respiratory Therapy/Physical Therapy/Nutritionist

Should discuss:

- Any interventions and goals of care
- Any barriers to care
- Any barriers to discharge

WALKING ROUNDS CHECK-LIST

	Person/Role Responsible for Reporting	Status	Action Plan/Follow Up Items
Patient Name			
Date and Day of Week			
Attending in charge and Team	MD/PA		
Identified surrogate/caregiver (if needed)	MD/PA		
Goals of care (aggressive/palliative/unknown/other)	MD/PA		
Expected discharge disposition	**CM/SW**		

WALKING ROUNDS CHECK-LIST

Out of bed in prior 24 hours? Walking? If not, why not?	**RN**		
Catheters/IVs/Pressure injuries/Nutritional Status	RN		
Working DRG/Diagnosis	MD/PA		
Expected LOS	MD/PA		
Day of hospitalization	CM/SW		
Expected discharge date	MD/PA		
What happened in prior 24 hours	**MD/RN**		

WALKING ROUNDS CHECK-LIST

Plan for next 24 hours. What can we expedite? What can be done as outpatient?	**MD/PA**		
Pending results of tests and consults? How will they impact on plan?	MD/PA		
Medication review: All current meds. Convert to PO? Discontinue? Home infusion?	MD/PA/ Pharmacist		
Barriers to next level of care/discharge? (clinical, functional, social, economic)	**MD/SW/CM/ RN/PA**		

IMPACT OF INTERDISCIPLINARY CARE ROUNDS

- Improved communication and teamwork across caregivers
- Reduced duplication and redundancy
- Reduced length of stay
- Improved patient flow
- Reduced errors
- Expedited discharge planning
- Increased collaboration and satisfaction among all members of the team

MEASURES NEEDED TO HOLD THE GAIN

- Number of days per week that rounds occur
- Number of disciplines involved
- Percentage of patients with a documented daily goal in their record
- Adherence to scripting and talking points
- Length of rounds – 60 – 90 seconds per patient

OUTCOME MEASURES

- Reduction in Length of stay
  - The primary nurse, clinical coordinator or CNS discuss team members' recommendations with the attending or consulting physician, and the recommendations are evaluated and implemented.
- Reduction in ICU patient days
  - Team members identify stable patients who can move out of ICU by reviewing their clinical picture, vital signs, treatment goals and diagnostic test results. The primary nurse or clinical coordinator collaborates with the physicians regarding patients identified for possible transfer.

- Reductions in morbidity and mortality
  - A proactive approach to patient care through collaboration and the use of evidence-based care bundles helps care goals become realities.
- Quick assessment
  - Walking interdisciplinary rounds enables the team to have a quick sense of patients' progress by looking at their appearance and communicating with them.
- Environmental check
  - Removing unnecessary supplies and linens is reinforced to the nurses and patient care technicians, as we strive to integrate this into hospital culture.

- Safety check
  - Bedside rounds provide another opportunity for rounding on patients at high risk for falls or who have the potential to pull their lifesaving devices or lines.
- Regulatory check
  - As assessment of the number of side rails used as a regulatory compliance check can be made during rounds.

- Patient satisfaction
  - Patients are glad to see members of the team in addition to the staff involved in their care, and appreciate the incorporation of holistic care.
- Staff satisfaction and education
  - Staff members share related information and evidence whenever necessary, and participate in the promotion of a culture of safety and quality.

- Ventilator days
  - Team members identify stable patients who can wean off ventilator or be removed from ventilator by reviewing their clinical picture, vital signs, treatment goals and diagnostic test results. The primary nurse or clinical coordinator collaborates with the physicians and respiratory therapists regarding patients identified for changes in ventilator use..
- Number of pharmacy changes such as discontinuing antibiotics
  - Did changes occur in a timely manner and when clinically appropriate
- Number of discharge delays
  - Associated with communication delays or care coordination delays

SUCCESS STORIES

Cincinnati Children's Hospital Medical Center (Cincinnati, OH)

Post implementation

- Staff, including bedside nurses, feel more knowledgeable about the care plan
- Order errors decreased from 9% to 1%
- Decreased overall daily time per patient (however, rounding took 20% longer)
- Increased patient satisfaction
- Increased faculty and learner satisfaction

SUCCESS STORIES

Concord Hospital Cardiac Surgery Program (Concord, New Hampshire)

Post implementation

- Decreased mortality by 50%
- Increased patient satisfaction to 99th percentile
- Improved staff satisfaction

MCG Health, Child and Adult Services (Augusta, Georgia)

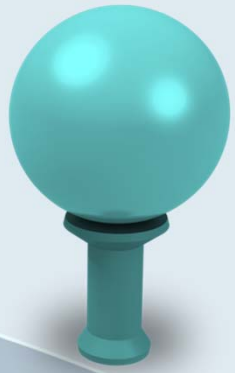
3 years post implementation

- Improved patient satisfaction from 10th to 95th percentile
- Decreased LOS by 50%
- Decreased RN vacancy rate from 8% to 0%
- Increased faculty and learner satisfaction

ULTIMATE GOALS

- Aim to understand and reduce variation
- Highlight the handoff as the transfer of professional responsibility
- Detect and correct vulnerabilities in the handoff

- Should not be seen as MORE work.



- Should be seen as THE work!

WALKING ROUNDS DO MAKE A DIFFERENCE

- Making the patient the center of activity creates a tremendous difference.
- Within 30 - 60 minutes, the team achieves:
  - patient interaction, focused quick assessment, plan of care discussions, safety check, environmental check, regulatory check and staff education.
- Within the current demands of healthcare, this culture of safety, transparency, efficiency, collaboration and autonomy makes a big difference in the quality of care patients receive.

"Patient-centeredness" is a dimension of health care quality in its own right... Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it.

- -- Don Berwick, IHI

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Feel free to contact us!

Toni Cesta
cestacon@aol.com

Bev Cunningham
bevcmc@hotmail.com

www.casemanagementconcepts.com

Questions?