The Impact of Care Coordination & Multidisciplinary Team on Value-Based Reimbursement

Bev Cunningham, MS, RN, ACM,
Toni Cesta, PhD, RN, FAAN

RELIAS LEARNING

Speakers

Toni Cesta, PhD, RN, FAAN

Founding partner of Case Management Concepts, LLC. 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. She has been active in the research and development of Case Management for over 20 years.

Beverly Cunningham, MS, RN, ACM

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 the former Vice President of Resource Management at Medical City Dallas Hospital.

RELIAS LEARNING

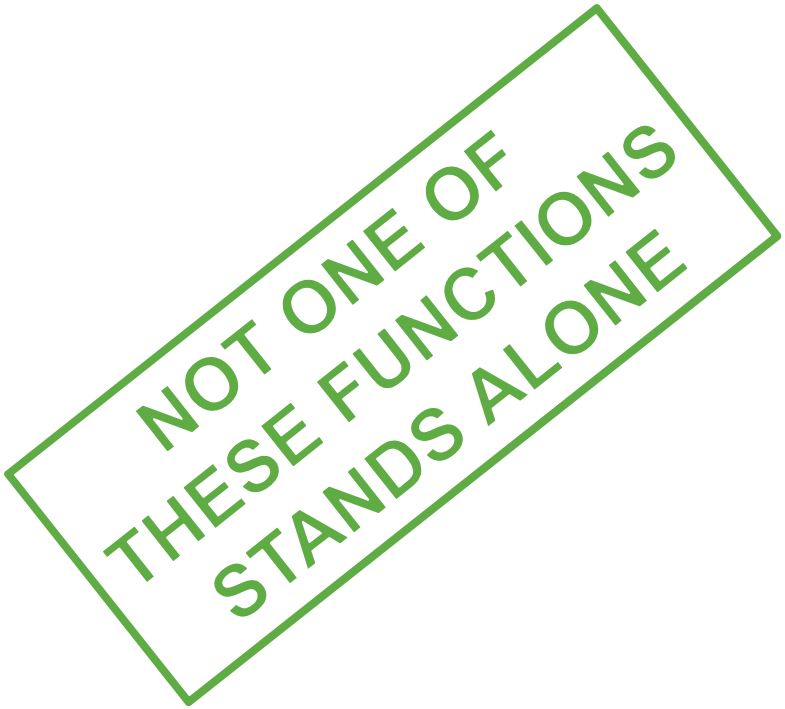
OBJECTIVES

- Identify key stakeholders for care coordination and multidisciplinary team effectiveness.
- Explain the impact of care coordination on value-based reimbursement outcomes.
- Develop effective teams and team goals.

RELIAS LEARNING

IT'S REALLY BACK TO THE BASICS: THE 4 FUNCTIONS OF CASE MANAGEMENT

- Utilization Management
- Care Coordination
- Transitional Planning
- Resource Management



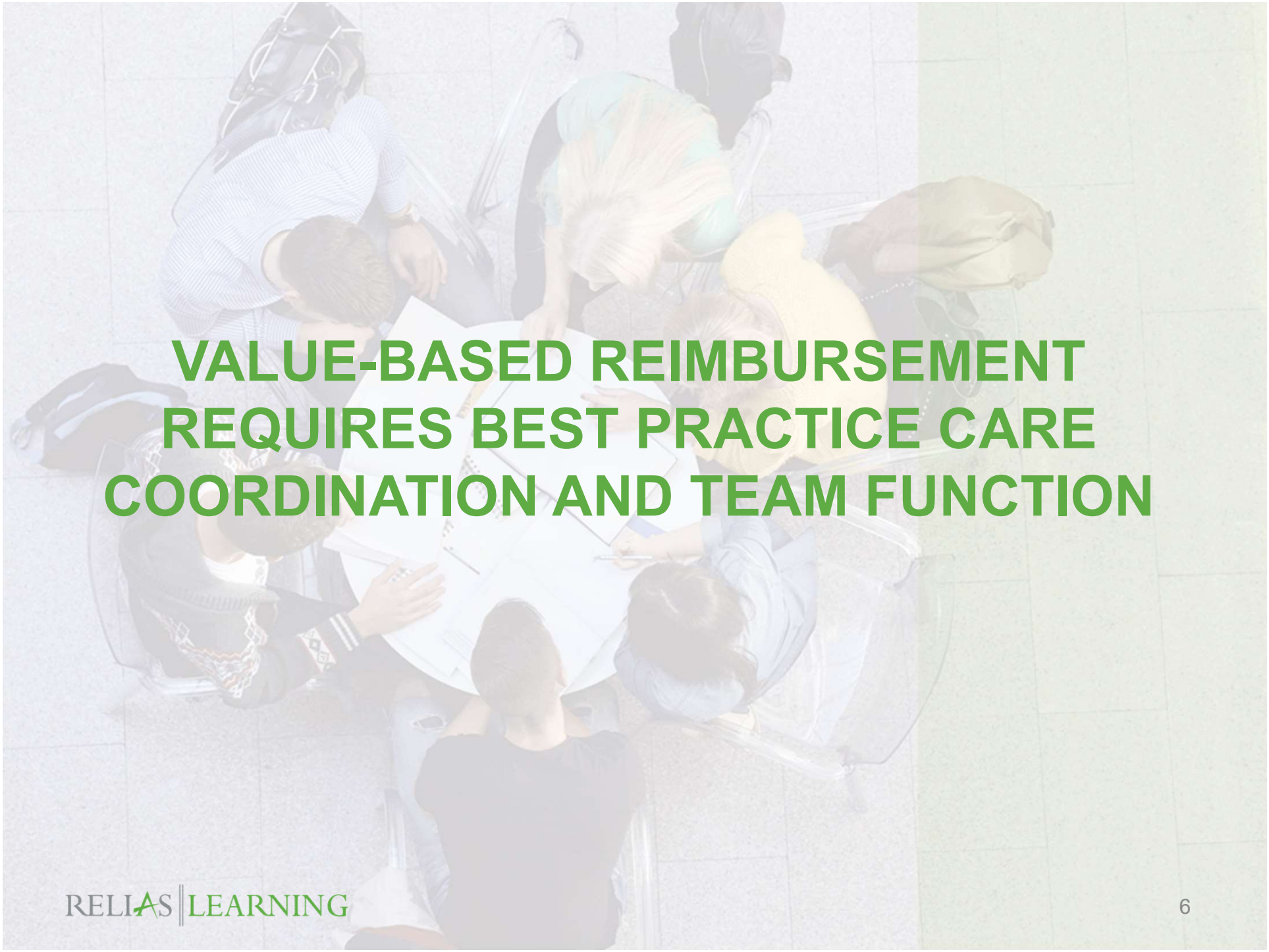
RELIAS LEARNING

TODAY'S BASIC FUNCTION TOPIC: CARE COORDINATION

Deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

National Center for Biotechnology Information

RELIAS LEARNING



VALUE-BASED REIMBURSEMENT REQUIRES BEST PRACTICE CARE COORDINATION AND TEAM FUNCTION

CMS TRANSFORMED

FROM

RELIAS LEARNING

IT'S ALL ABOUT EFFECTIVE CARE COORDINATION

And effective care coordination is the core business of hospitals, and a core responsibility of the case management department

ELEMENTS OF BEST PRACTICE CARE COORDINATION

- Patient-centered
- Supportive of family and informal caregivers
- Accessible
- Interdisciplinary approach
- Focus on chronic care and health care transitions
- Bridge health and social services
- Employ comprehensive assessment
- Implement and monitor flexible care plan
- Hospital-community collaboration
- Coordinated and collaborative care teams

CMSA Today Issue 4 2015

RELIAS LEARNING

INFLUENCES ON EFFECTIVE CARE COORDINATION

RELIAS LEARNING

NEGATIVE IMPACTS ON EFFECTIVE CARE COORDINATION??

- Poor patient flow
- Case management focusing on themselves rather than focusing on the process
- Consulting specialist timeliness
- Delays in care
- Availability and responsiveness of ancillary services

RELIAS LEARNING

NEGATIVE IMPACTS ON EFFECTIVE CARE COORDINATION

- Timeliness of tests and reporting results
- Ability to schedule timely
- Effective communication
- Focused treatment on the reason the patient was admitted (not focusing on “rabbit trail” treatment)
- Avoidable days
- Ineffective discharge planning
- Unfunded/underfunded patients with minimal resources post discharge

RELIAS LEARNING

NEGATIVE IMPACTS ON EFECTIVE CARE COORDINATION?

- Availability of post acute care resources, often geographical
- Ineffectiveness of team
- Documentation
- Complications
  - Patient acquired
  - Hospital acquired
- Ineffective case management and/or hospital leadership

RELIAS LEARNING

CASE MANAGEMENT ROLES IN EFFECTIVE CARE COORDINATION

CASE MANAGEMENT CARE COORDINATION TRANSITIONS

- Case finding
- Patient assessment
- Resource assessment
- Goal setting: What needs to be accomplished and time frame for accomplishment
- Planning: Coordination with all disciplines and all levels of care
- Implementation
- Compliance requirements
- Monitoring/reassessment; continued interdisciplinary coordination
- Documentation

Making care seem seamless to the patient, family and/or caregiver

RELIAS LEARNING

CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Clinical competence and experience
- Timely identification of transition plans
  - Sets milestones, or next steps for patients
  - Acts as liaison with families
  - Facilitates care plan with physicians, nursing and ancillary services
  - Identifies anticipated LOS and updates, as patient transitions
  - Reassesses and updates plans

RELIAS LEARNING

CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Focus on evidence based best practices
- Monitor outcomes
  - Clinical
  - Financial
  - Compliance
- Understand barriers to transitions for individuals and groups of patients: Identify and intervene through coordination
- Focus on both plan for day and plan for stay

RELIAS LEARNING

CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Collaborate with key ancillary staff
- Consistent tracking of avoidable days
- Prompt intervening for delays and barriers

RELIAS LEARNING

CASE MANAGEMENT DIRECTOR'S ROLE IN CARE COORDINATION

- Evaluates current staffing ratios and ensures appropriate staff
- Ensures that assigned roles fit individual skill set
- Ensures that staff are equipped with necessary tools, oriented, and educated appropriately
- Responsible for data gathering and reporting

RELIAS LEARNING

TRANSITION COORDINATOR

- RN case manager or social worker, depending on job description
- Knowledge
  - Hospital processes and how to connect patient with the next level of care
  - Payer rules and regulations
  - Organizations and resources in the community
- Experience in coordinating care for complex patients
- Must quickly and efficiently develop discharge plan
- Coordinates with RN case manger, social worker, complex discharge planning specialist and/or patient navigator

Hospital Case Management November 2016

RELIAS LEARNING

TRANSITION COORDINATOR

- Lower case loads than other staff to allow time to focus on patients
- Could follow patients up to 90 days post discharge
- Could required flexible hours, such as 11 am -7pm or 12 noon to 9 pm
- Bundled payment patients (if the proposed bundles go into effect) could increase the case load of the transition coordinator
- Ability to educate patients and/or families
- Consider piloting this position with a high-risk group of patients, or on a high-risk unit

Hospital Case Management November 2016

RELIAS LEARNING

BUSINESS CASE MANAGER

- Team lead or supervisor role
- Focuses on the business side of case management
  - Becomes super user of Hospital Compare and other comparative resources
  - Knowledge expert of value-based reimbursement and case management's impact
- Manages understanding straddling two payment systems
  - Coordinates education of staff
  - Resource for case management leaders
  - Provides recommendations to case management leaders
  - Develops competencies for staff related to alternative payment models

RELIAS LEARNING

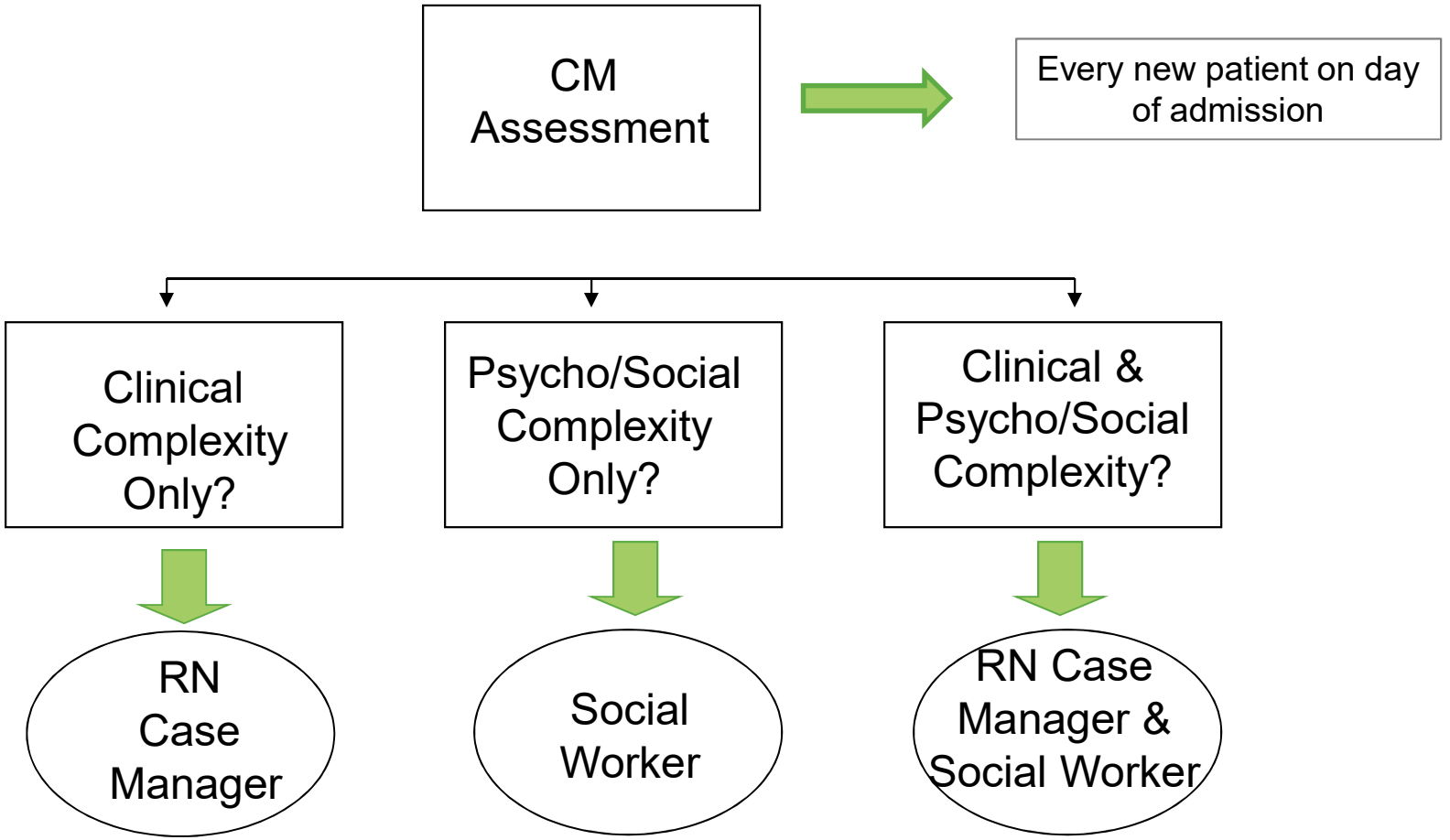
BUSINESS CASE MANAGER

- Coordinates roles of case manager, social worker, and clerical staff related to value-based reimbursement initiatives and processes
- Aligns hospital with appropriate post-acute care providers
- Analyzes and reports outcomes related to value-based reimbursement

RELIAS LEARNING

STRATEGIES OF EFFECTIVE CARE COORDINATION

TRIAGE PLAN FOR CARE COORDINATION AND TRANSITION PLANNING



RELIAS LEARNING

WHAT ABOUT THE PATIENT WHO NEEDS MORE COMPLEX CARE COORDINATION?

- High risk chronic condition
- Frequent admitter: ED, observation or inpatient
- LOS greater than __X___ number of days
- Patients of specific physicians (those most likely to have long stays and/or avoidable days)
- Increased avoidable days
- Unfunded and underfunded
- Multiple diagnoses and high charges
- Psycho/social issues
- Complex patients with minimal family/caregiver support

RELIAS LEARNING

MULTIDISCIPLINARTY TEAM CARE COORDINATION RESPONSIBILITY GRID

	Compliance Require-ments	Admission Assessmen t	Family Assessment	Core Measures	Hospital Acquired Conditions	Care Coordination Rounds	Patient-Family Confer-ence	Education Plan	Readmission Reduction Strategies
CASE MANAGER									
SOCIAL WORKER									
NURSING									
QUALITY MGMT									
PHYSICIAN									
APN or PA									
EDUCATOR									
PATIENT NAVIGATOR									
TRANSITION COORDINATOR									
DISCHARGE PLANNING SPECIALIST									
ANCILLARY STAFF									
BUSINESS CASE MANAGER									

THE SILOS OF CARE COORDINATION

It's no longer just about us
It includes the patient and family/caregiver

ROLE OF THE TEAM IN CARE COORDINATION

- Identify the team
- Assure each team member understands their critical role

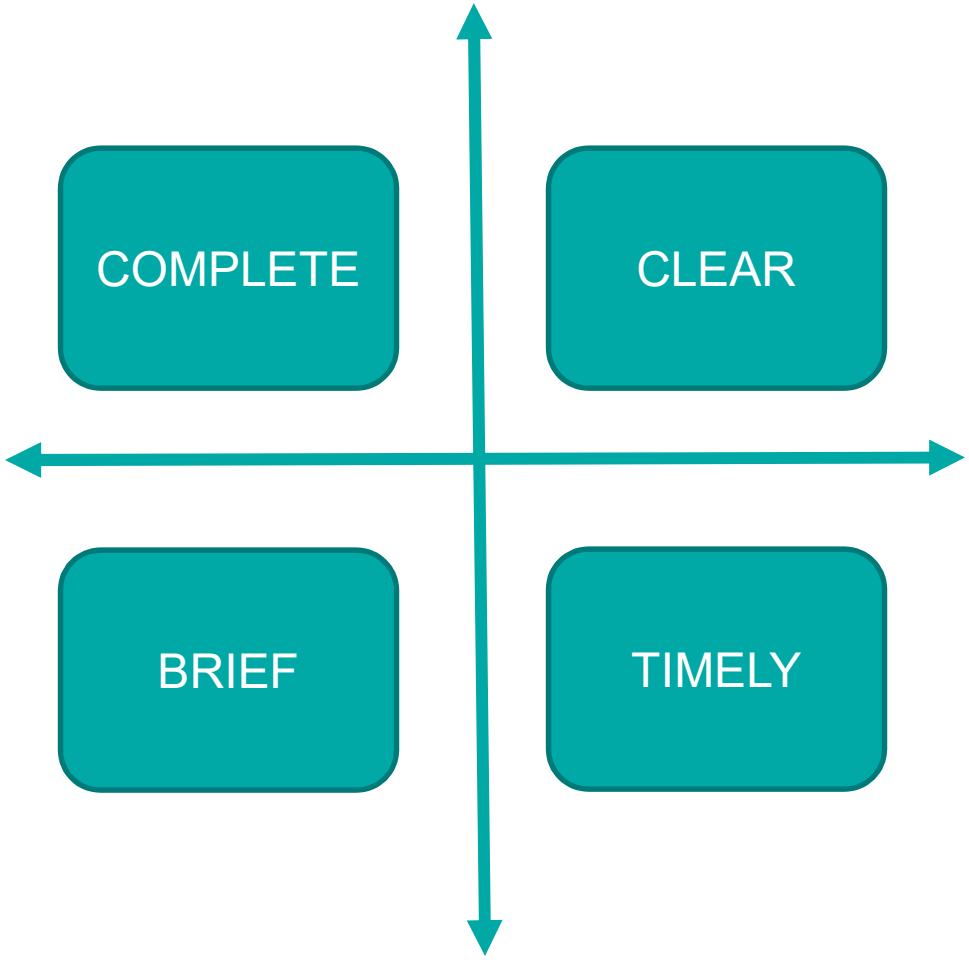
"Utilizing cohesive teams limits adverse events (AE) (e.g. including morbidity/mortality), improves patient outcomes, decreases patient length of stay (LOS), and increases patient satisfaction"

Surgical Neurology International, 2014
National Institutes of Health

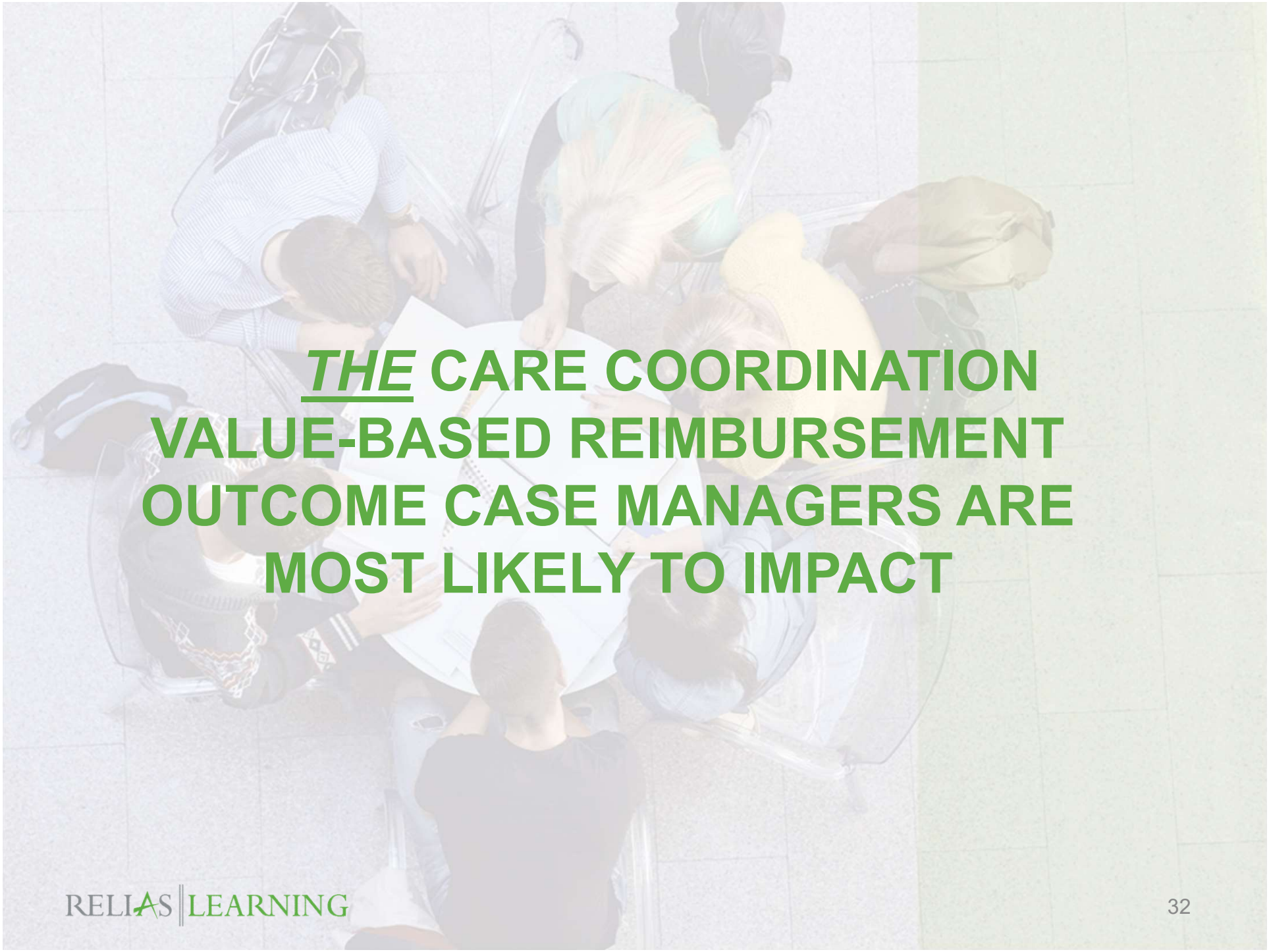
RELIAS LEARNING

CARE COORDINATION GOALS FOR POSITIVE VALUE-BASED REIMBURSEMENT OUTCOMES

EFFECTIVE COMMUNICATION FOR TRANSITIONS

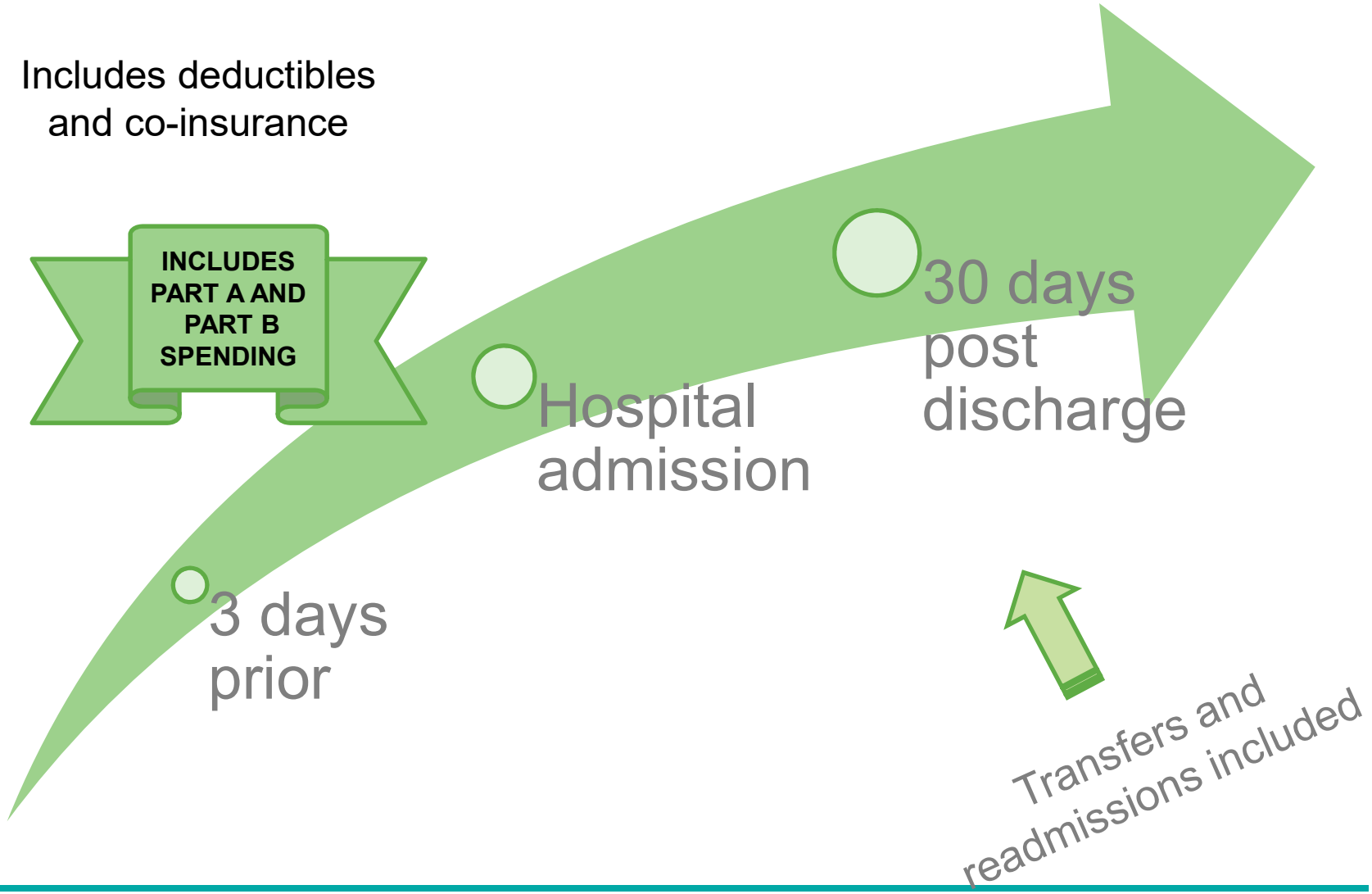


RELIAS LEARNING



THE CARE COORDINATION VALUE-BASED REIMBURSEMENT OUTCOME CASE MANAGERS ARE MOST LIKELY TO IMPACT

THE CARE COORDINATION VALUE-BASED REIMBURSEMENT MEASURE CHALLENGE



MEDICARE SPENDING PER BENEFICIARY (MSPB)

- CMS stated purposes (2016)
  - Incentivize hospitals to coordinate care
  - Reduce system fragmentation
  - Improve efficiency
- Find your hospital's spending per beneficiary by location: https://www.medicare.gov/hospitalcompare/Data/spending-per-hospital-patient.html (1-3 days prior index hospitalization, during index hospitalization, 1-30 days post hospitalization, and complete episode)
- National average: 0.99 Find your hospital's average, with comparison to the nation and state at www.medicare.gov/hospitalcompare (Use tab: Payment and Value of Care)

RELIAS LEARNING

OTHER MSPB INFORMATION ON HOSPITAL COMPARE

- Use tab: “Payment and Value of Care”
  - Medicare spending per beneficiary, mortality and average payments for specific diagnoses
    - Heart attack
    - Heart failure
    - Pneumonia
- Payment for the 3 diagnoses, are average payment
- Value for the 3 diagnoses are mortality results
- Results for heart attack, heart failure and pneumonia
  - No different, greater or less than the average payment
  - No different, greater or less than the national rate for mortality

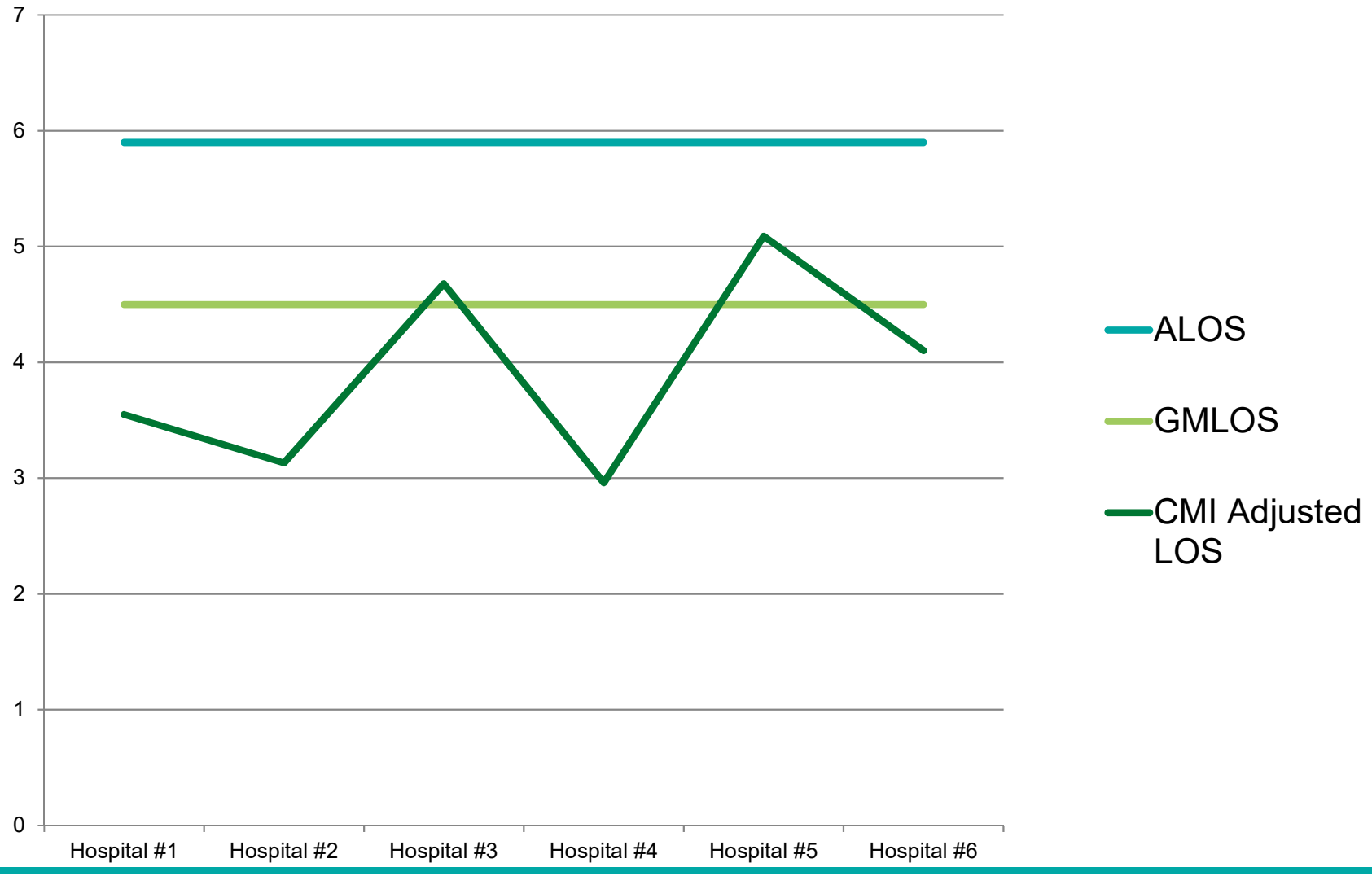
RELIAS LEARNING

LENGTH OF STAY AND CARE COORDINATION

- Average inpatient length of stay (LOS)
  - All patient LOS 4.5 (2012 AHRQ)
  - Medicare LOS 5.5 (AHA 2014—down from 6.7 in 1994)
    - Medicare fee for service LOS 5.6
    - Medicare advantage LOS 5.2
  - Medicaid LOS 4.3; commercial LOS 3.8; uninsured LOS 4.0 (2012 AHRQ)
- Expected LOS is impacted by complications and comorbidities from 10 codes
- Expected LOS may vary by group providing the results
- Compare your average LOS (ALOS) to the CMS GMLOS—geometric mean length of stay
- Case mix adjust your ALOS by dividing your average LOS by your case mix index

RELIAS LEARNING

YOUR HOSPITAL LENGTH OF STAY BASED ON YOUR CMI



RELIAS LEARNING

INTERDISCIPLINARY COLLABORATIVE IMPACT ON CARE COORDINATION

- Bedside rounds
- Effective multidisciplinary discharge planning rounds
- Long stay care conferences
- Unfunded/underfunded care conferences
- Patient/family care conference
- Connect patients to OP services to decrease readmissions
- Discharge lounge
- Care coordination has a direct impact on LOS, which has a direct impact on Medicare Spending Per Beneficiary

RELIAS LEARNING

YOUR DEPARTMENT'S TOP 12 CARE COORDINATION STRATEGIES FOR OPTIMAL VALUE-BASED REIMBURSEMENT

CARE COORDINATION STRATEGIES

1. Develop LOS goals for predictable populations first: population where there is a likelihood for standardization
2. Identify critical team members
3. Develop process time frame for goals for predictable populations
   - Pre-hospital phase
   - Hospital phase, including operative phase, if appropriate
   - Pre-discharge phase
   - Discharge
   - Post-discharge, especially patients with readmission risk

RELIAS LEARNING

CARE COORDINATION STRATEGIES

- For each process time frame identify expectations for the core functions of case management: utilization management, care coordination, discharge planning and resource management
  - Pre-hospital phase
  - Hospital phase, including operative phase, if appropriate
  - Pre-discharge phase
  - Discharge
  - Possible readmission

4. Track and report
   - LOS
   - Avoidable days
   - Discharge destinations
   - Readmissions
   - Denials

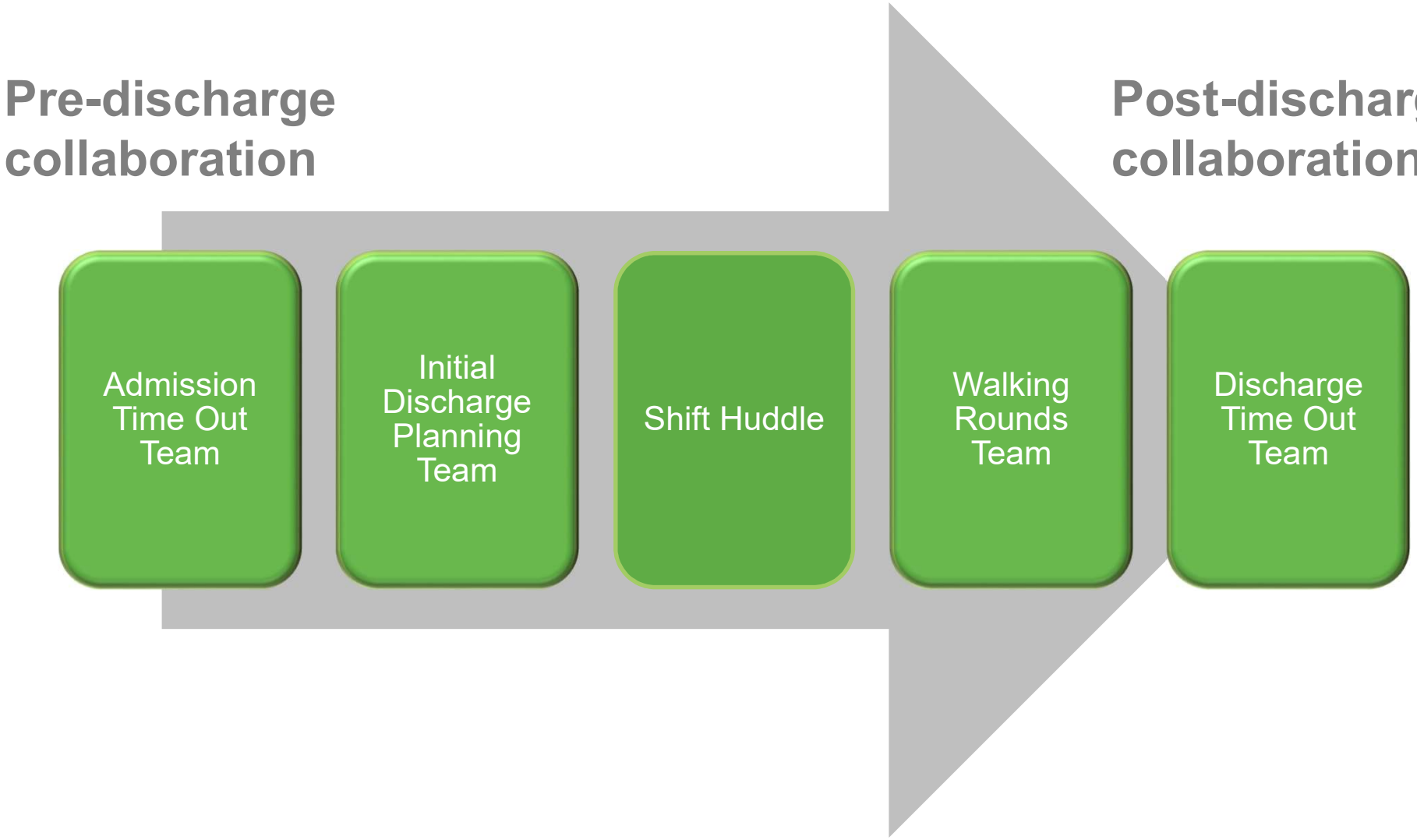
RELIAS LEARNING

CARE COORDINATION STRATEGIES FOR LONG STAY PATIENTS: #5

- Identify most vulnerable groups of long stay patients
  - Diagnosis
  - Dual eligible
  - Other
- Define long stay: Patients staying longer than a specific number of days
- Develop approach
  - Identify patients
  - Have long stay rounds
  - Include physician advisor
  - Partner with ancillary and nursing colleagues
- Use long stay patients as case studies or grand rounds to improve future lengths of stay

RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION: #6



RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION

- Review medical necessity
- Identify any present on admission diagnosis
- Initiate any core measures
- Readmission risk
- Specific needs—clinical, financial, family, psycho/social
- Implement appropriate compliance requirements
  - 2 midnight rule
  - Discharge planning assessment and reassessment
  - MOON delivery, if observation service

RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION

- Extended discharge planning needs from admission time out
- Based on initial assessment
- Must be conducted face to face

RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION

Daily Shift Huddle(s)

- Shift discussion with key representatives from multidisciplinary team
- Continued stay medical necessity
- Barriers to discharge
- Other critical patient needs

RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION

- Multidisciplinary rounding at bedside
- Includes patient and family, as appropriate

RELIAS LEARNING

TEAMS IMPACTING EFFECTIVE CARE COORDINATION

- Allows staff to have the opportunity to ensure that all appropriate actions have been taken before patient leaves hospital
- Review discharge plan
- Identify likelihood for readmission
- Complete core measures requirements
- Close the loop on any needs identified in any earlier team meetings

RELIAS LEARNING

CARE COORDINATION DOCUMENTATION: #7

MEDICAL RECORD

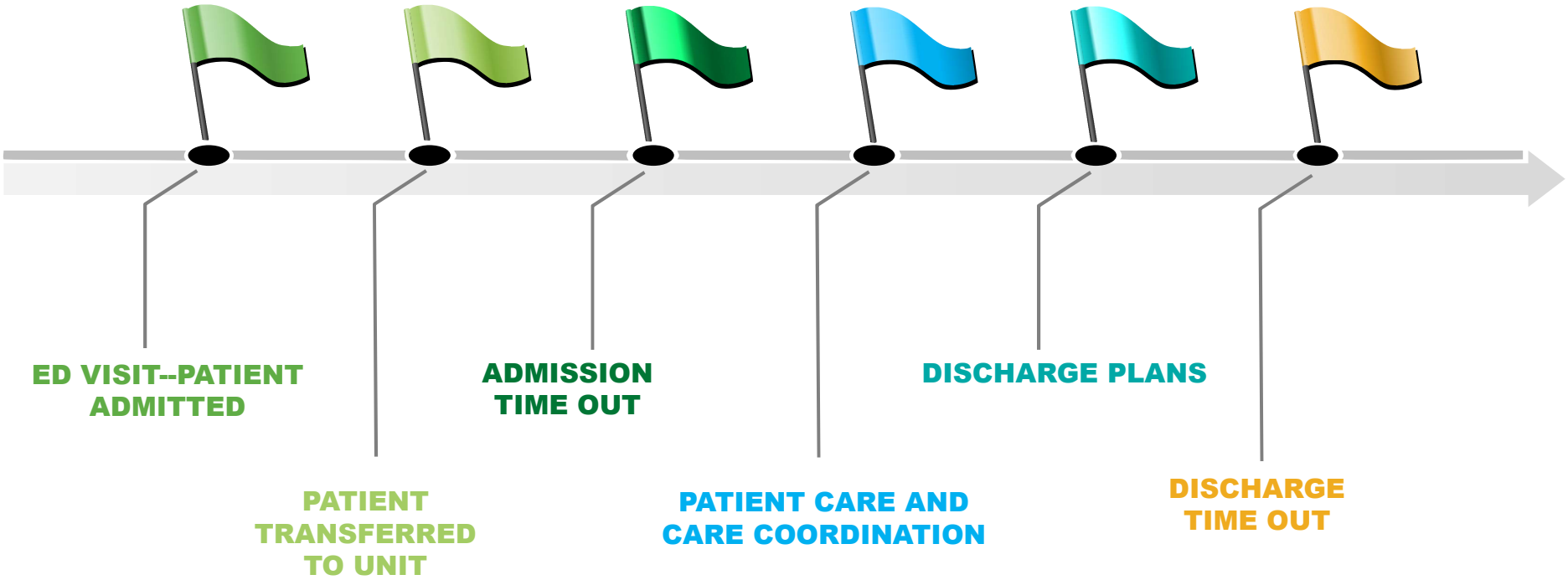
- Outcomes of assessment
- Communication (except with payer), referrals, interventions
- Plan of care (from the assessment)
- Record of interdisciplinary team meetings
- Record of family meetings
- Anticipated discharge date (depending on agreement with physician)
- Expected discharge disposition

CASE MANAGEMENT SOFTWARE (NOT IN MEDICAL RECORD)

- Communication with payer
- Variances/avoidable days (in case management software)
- Agreement or disagreement with denials identified by payer
- Anticipated discharge date

RELIAS LEARNING

EFFECTIVE TIME OUT: #8



RELIAS LEARNING

HISTORY OF THE TIME OUT

- 1999 Institute of Medicine (IOM): "To Err Is Human" identified surgical injuries, near misses and deaths
- 2003: Time out for procedures first identified as National Patient Safety Goal to prevent wrong sided surgery
- Nonprocedural time out
  - July 2011: Society for Hospital Medicine published an article, Critical Conversations: A Call for a Nonprocedural "Time Out"
  - Critical conversations tool:
    - Innovative communication tool to potentially limit communication failures at critical junctures
    - Purpose: Ensure high quality and safe care

RELIAS LEARNING

DISCHARGE TIME OUT

Purpose

- Identify risk areas for patient discharge and transition to next level of care: Readmission, quality, finance, care coordination, appropriate transition to next level of care, safe discharge, compliance, patient choice, patient experience, CDI
- Improve relative lack of attention to detail from hospital team at time of discharge (compared to admission process)

RELIAS LEARNING

DISCHARGE TIME OUT: INSITUTE FOR HEALTHCARE IMPROVEMENT RECOMMENDATIONS

- Schedule the date and time of discharge with the patient and family—place on white board
- Orchestrate the discharge by completion of the following (one day ahead of time)
  - Education
  - Medication reconciliation
  - Notify all ancillary services (by whiteboard, extranet notification and/or phone call)
- Synchronize admissions and transfers to discharge schedule

RELIAS LEARNING

DISCHARGE TIME OUT ACCOUNTABILTY GRID

ACTION	CM	SW	NURSING	PHYSICIAN	ANCILLIARY SERVICE	MID LEVEL	QUALITY	CDI	POST ACUTE CARE PROVIDER
ADM ASSESSMENT	X		X	X	X				
READMISSION RISK	X		X	X					X
QUALITY METRICS			X	X			X	X	
FINANCE METRICS	X	X		X		X			
CARE COORDINATION METRICS	X	X		X		X			X (Through planning to transition patient home as soon as possible)
COMPLIANCE METRICS	X	X	X (2^{ND} IM)	X					
PATIENT EXPERIENCE SURVEY	X	X	X	X		X			
CDI METRICS				X					X

RELIAS LEARNING

DISCHARGE TIME OUT CAN BE COORDINATED BY VARIOUS CASE MANAGERS

- RN case manager
- Social worker
- Complex discharge planning social worker
- Perioperative case manager: patients discharged same day
- ED case manager and/or social worker—for patients held in ED, but never transferred to floor

RELIAS LEARNING

OTHER STRATEGIES FOR EFFECTIVE CARE COORDINATION

- Huddles
- Care Conferences
- Walking Rounds
- Physician Rounds

HUDDLES: #9

- 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, social worker (if appropriate)—may be with or without hospitalist
- Best if scheduled at same time each day
- Allows each huddle member to be prepared with outcomes, questions, concerns
- May not need to include every patient
- Should include patients with outstanding issues identified during morning rounds

RELIAS LEARNING

PATIENT CARE CONFERENCES: #10

- 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

RELIAS LEARNING

WALKING ROUNDS: #11

- Key care coordination strategy
- Real-time in-person exchange of information
- Makes goals and plan of care for each patient clear to all members of team
- Formal and organized approach to patient care
- Ensures patient/family receive consistent and accurate information
- Increases efficiency and safety of patient care
- Decreases gaps
- May be proactive process to eliminate avoidable days or delays

RELIAS LEARNING

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), The Joint Commission and The Institute of Medicine
  - Mechanism for interdisciplinary collaboration
  - Decision support at patient care level
  - Evidence-based management processes

RELIAS LEARNING

WALKING ROUNDS AS AN ADJUNCT TO CARE COORDINATION

- 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)
  - Transitions out of hospital
- Scripting your rounds (Attachment 1)
- Share patient tips and checklist for patients and caregivers (Attachment 2)

RELIAS LEARNING

ROUNDS FOCUS – COORDINATION OF CARE AND COMMUNICATION

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

COMMUNICATION

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

RELIAS LEARNING

ROUNDS: PLAN FOR THE DAY GOALS

- Determine key goal, or goal for day
- Document goals so they are accessible to care team, patient and family
- Provide daily feedback on goals to refine and reset them for current day
- Examples
  - DC oxygen by 4 pm
  - Wean off vasopressors by midnight
  - Mobilize patient to walk 20 feet
  - Initiate hospice referral

RELIAS LEARNING

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

RELIAS LEARNING

STUDY OF IMPACT OF BEDSIDE INTERDISCIPLINARY ROUNDS ON LOS AND COMPLICATIONS

- Occurred daily at 10:00 or 10:30 (2 research groups—control and study group)
- Transformed daily rounds in a conference room model to structure bedside model with scripted roles
- Attendees: Hospitalist, staff nurses, unit medical director, nurse manager, social worker, case manager
- Focus: Plan of care and disposition with structured script
- Did not last longer than 30 minutes
- No difference in LOS in the 2 study groups, but LOS was decreased for patients transferred to the study unit
- Team results
  - Benefits ranked highest: Communication, coordination and teamwork
  - Greatest barriers: Efficiency and outcomes
- Needs to be further studies

Journal of Hospital Medicine
March 2017 (See resource slide)

RELIAS LEARNING

STUDY IMPACT OF STANDARDIZED ATTENDING ROUNDS

- Objective to measure impact of standardized bedside round on patient satisfaction with rounds
- Interventions
  - Pre-rounds huddle
  - Bedside rounds
  - Nurse integration
  - Real-time order entry
  - Whiteboard updates
- Control teams continued usual practices
- Results
  - Increased patient satisfaction
  - Patients felt more cared for by team
  - Intervention shortened duration of rounds by 8 minutes
  - Team perceived intervention rounds as lasting longer and lower satisfaction

Journal of Hospital Medicine
March 2017 (See resource slide)

RELIAS LEARNING

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.

RELIAS LEARNING

ENGAGING PATIENT AND FAMILY IN ROUNDING PROCESS

- Invite families to participate – this can be very powerful
- Orient the family to rounds before inviting them include:
  - Focus
  - Routine
  - Expectations
- Post time of rounds
- When rounds begin, start with brief introduction to patient and family
  - Purpose
  - Time
  - Encourage participation, but develop boundaries for “rabbit trail” discussions

RELIAS LEARNING

CASE MANAGER ROUNDING PROCESS

- Review admission status – inpatient versus observation
- Review case management admission assessment
- Review initial discharge plan and payer
- Review expected LOS and discharge date

- Discuss expected LOS 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

RELIAS LEARNING

SOCIAL WORKER ROUNDING PROCESS

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

- Discuss expected LOS 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

RELIAS LEARNING

TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

GENERAL INFORMATION REGARDING ROUNDS

Rounds must occur daily, Monday through Friday, at a consistent time

Ideally, rounds would also occur on weekends

All critical members of interdisciplinary team are expected to attend

Physician and nurse manager will facilitate rounds

PROCESS FOR ROUNDS

Each person has talking points (Attachment 3)

CHECK LIST (Attachment 4)

RELIAS LEARNING

OUTCOME MEASURES FROM WALKING ROUNDS

- Reduction in Length of stay
- Reduction in ICU patient days, including ventilator days
- Reductions in morbidity and mortality
  - Proactive approach to patient care through collaboration and use of evidence-based care bundles helps care goals become realities
- Quick assessment and checks
  - Environmental check
  - Safety check
  - Regulatory check

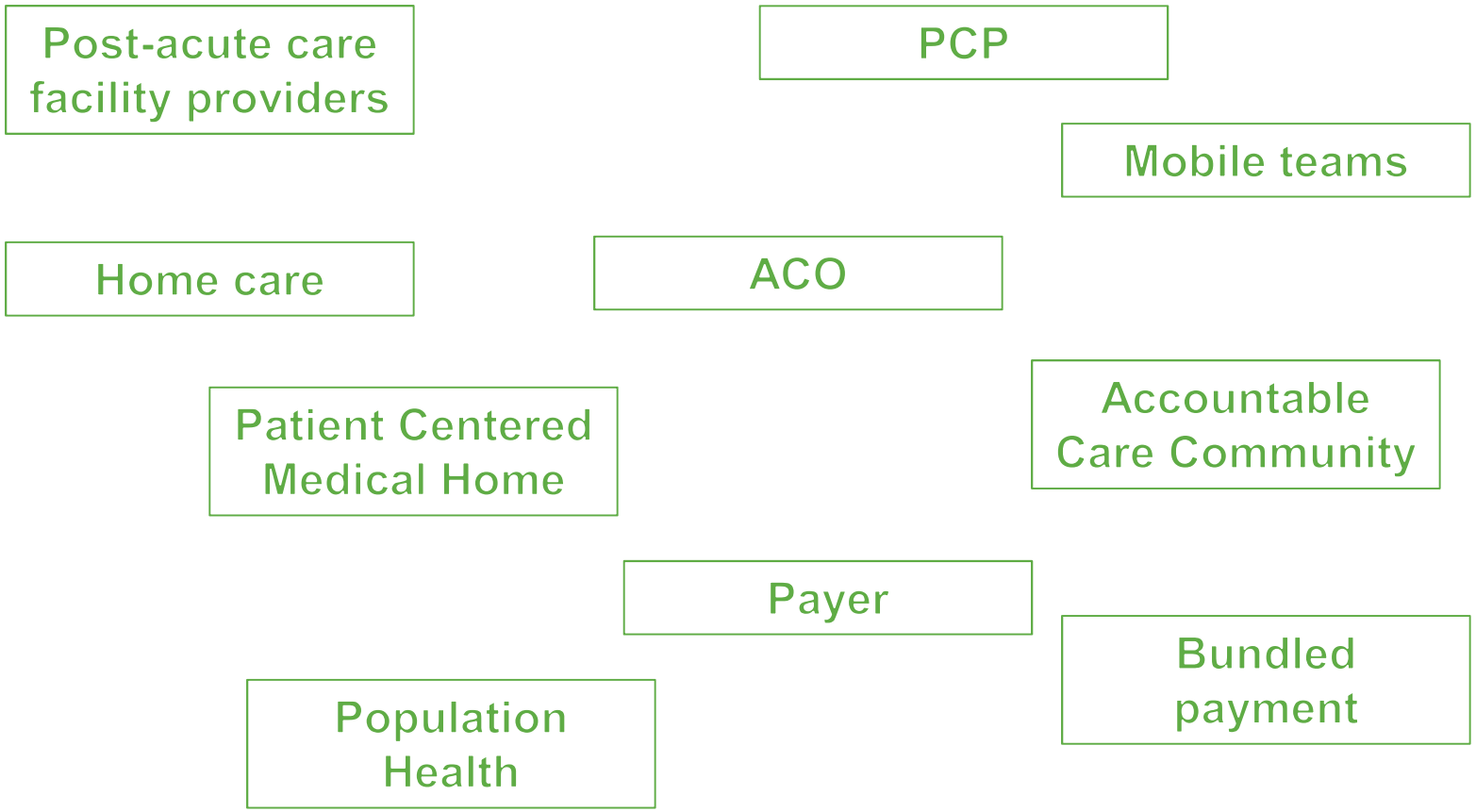
RELIAS LEARNING

OUTCOME MEASURES FROM WALKING ROUNDS

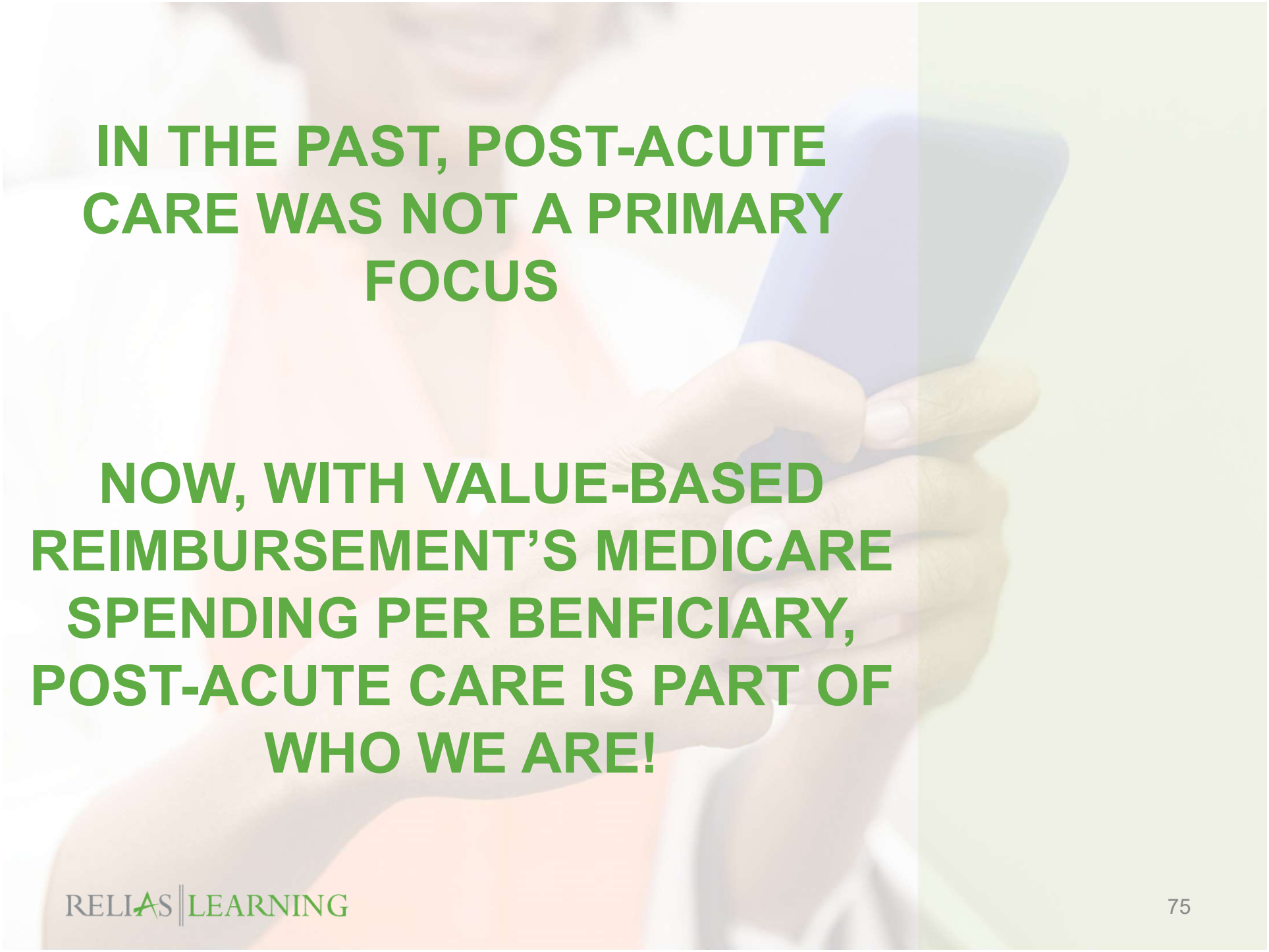
- Decrease in number of pharmacy changes
- Decrease in number of discharge delays
- Improved patient satisfaction
- Improved staff satisfaction and education

RELIAS LEARNING

CARE COORDINATION MUST ALIGN WITH NEXT LEVEL OF CARE PROVIDERS #12



RELIAS LEARNING



IN THE PAST, POST-ACUTE CARE WAS NOT A PRIMARY FOCUS

NOW, WITH VALUE-BASED REIMBURSEMENT'S MEDICARE SPENDING PER BENFICIARY, POST-ACUTE CARE IS PART OF WHO WE ARE!

EXPECTED RESULTS FROM EFFECTIVE POST-ACUTE CARE COORDINATON

- Decreased ED utilization
- Decreased readmissions
- Decreased costs
- Improved quality
- Improved patient satisfaction

Not just in the hospital, but across the continuum

RELIAS LEARNING

COORDINATING CARE WITH POST-ACUTE CARE

- No longer can we refer to a post-acute care provider (facility or home care) without providing the patient with complete regarding quality
- Post-acute care facilities/home care must prove their "worth" to be a part of our network
- We must expect high quality care and outcomes for our hospital-owned or system-owned acute care providers
- We must be aware of any network in which the patient is involved
  - ACO
  - Bundled payment
  - PCMH
  - Population health

RELIAS LEARNING

PATIENT CENTERED MEDICAL HOME

- Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care
- Primary care medical home, also referred to as the patient centered medical home, advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care
- 5 functions
  - Comprehensive medical care
  - Patient-centered
  - Coordinated care
  - Accessible services
  - Quality and safety

RELIAS LEARNING

POPULATION HEALTH MANAGEMENT (PHM)

- Aggregation of patient data across multiple health information technology resources; analysis of that data into a single, actionable patient record; actions through which care provider improve clinical and financial outcomes
- Typically, PHM programs use a business intelligence tool to aggregate data and provide a comprehensive clinical picture of each patient--using that data, providers track, and improve, clinical outcomes while lowering costs
- Best-in-class PHM program brings clinical, financial and operational data together from across continuum and provides actionable analytics for providers to improve efficiency and patient care
- Optimally the business intelligence tool is real-time

RELIAS LEARNING

MOBILE TEAMS (Valley Hospital Mobile Integrated Healthcare Program)

- Often used when patients with cardiopulmonary issues don't qualify for home health, or refuse post acute care services (collaboration with ED and home care)
- Mobile team includes paramedic, ED RN, critical care nurse and/or EMT
- All ages and payers are seen
- Usually one visit, but may include more, especially if pt doesn't understand discharge plan
- Assessment
  - Home safety
  - Clinical
- Much of visit includes education

RELIAS LEARNING

ACCOUNTABLE CARE COMMUNITY

- Goal: Improve care coordination and address socioeconomic determinates of health for vulnerable Medicare and Medicaid populations
  - Social factors with poor health and chronic disease
  - Barriers to care access
  - Poverty
  - Low health literacy
  - Poor lifestyle choices
- Focus areas
  - Patient awareness of available community services
  - Connecting patients with tools to address socioeconomic-health needs
  - Building provider relationships across community for a robust network for full range of patient issues

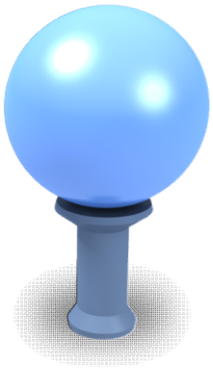
RELIAS | LEARNING

STANDARDIZED WORK PARADIGM

Old Paradigm

I know you'll be able to figure it out.

Just get it done the best way you can.



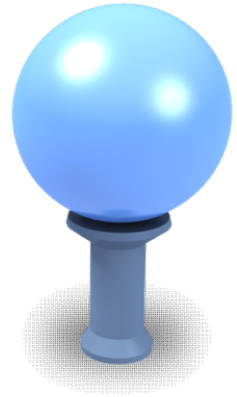
New Paradigm

In order to have consistent results and to positively impact value-based reimbursement we must do things the same way every time.

RELIAS LEARNING

CARE COORDINATION

- Should not be seen as MORE work.



- Should be seen as THE work!

RELIAS LEARNING

"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

INTERNAL AND EXTERNAL TEAMS TO MOVE FROM VOLUME TO VALUE

INTERNAL TEAMS

- Physicians
- Physician advisor
- Nursing
- Ancillary services
- Midlevel practitioners
- Service line leaders
- RN case managers
- Social workers
- Case management extenders
- Leadership team members
- Executive team champion(s)

EXTERNAL TEAMS

- Next level of care providers
  - Internal to your facility
  - Outside your facility
- Payers who may delay discharges
- Payer medical directors

RELIAS LEARNING

ASSESS YOUR DEPARTMENT'S EFFECTIVENESS IN CARE COORDINATION

RESOURCES

- The Impact of Bedside Interdisciplinary Rounds on Length of Stay and Complications (Society for Hospital Medicine March 2017)

  Andrew S. Dunn, MD, MPH, Maria Reyna, MD, Brian Radbill, MD, Michael Parides, PhD, MS, MPhil, Claudia Colgan, Tobi Osio,Ari Benson, MD, Nicole Brown, MD, Joy Cambe, Margo Zwerling, MPH, Natalia Egorova, PhD, MPH, Harold Kaplan, MD

- Standardized Attending Rounds to Improve the Patient Experience: A Pragmatic Cluster Randomized Controlled Trial (Society for Hospital Medicine March 2017)

  Bradley Monash, MD, Nader Nafafi, MD, Michelle Mourad, MD, Alvin Rajkomar, MD, Sumant R. Ranki, MD, Margaret C. Fang, MD, MPH, Marcia Glass, MD, Dimiter Milev, MPH, Yile Ding, MD, Andy Shen, BA, Braley A. Sharpe, MD, James D. Harrison, MPH, PhD

RELIAS LEARNING

RESOURCES

- Medicare.gov 800-MEDICARE The official U.S. government site for people with Medicare
- National Alliance for Care giving www.caregiving.org Support for family caregivers and the professionals who serve them
- National Association of Professional Geriatric Care Managers 520-881-8008 www.caremanager.org Information on geriatric care management, and a free online care manager search tool
- National Family Caregivers Association 800-896-3650 www.nfcacares.org Support for those who care for chronically ill, aged, or disabled loved ones
- Society for Social Work Leadership in Health Care 866-237-9542 www.sswlhc.org Dedicated to promoting the principles of social work within the health care system
- United Hospital Fund 212-494-0700 www.uhfnyc.org Publisher of *Always on Call: When Illness Turns Families into Caregivers*
- Federal Register, April 7, 2011 Update of provisions in Section 302 of Affordable Care Act

RELIAS LEARNING

RESOURCES

- Area Agencies on Aging (AAAs) Help adults age 60 and older and their caregivers. To find the AAA in your area, call The Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST), or visit www.eldercare.gov.
- Long-Term Care (LTC) Ombudsman Program Advocate for, and promote the rights of, residents in LTC facilities. Visit www.Ltcombudsman.org.
- Aging and Disability Resource Centers (ADRCs): Offer resources to help people of all incomes and ages stay independent. Visit www.adrc-tae.org.
- Centers for Independent Living (CILs): Help people with disabilities live independently. For a state-by-state directory of CILs, visit www.ilru.org/html/publications/directory/index.html.
- State Technology Assistance Project: Has information on medical equipment and other assistive technology. Call 1-703-524-6686 to get the contact information for your state, or visit www.resna.org.
- National Long-Term Care Clearinghouse: Provides information and resources to plan for your long-term care needs. Visit www.longtermcare.gov.
- National Council on Aging: Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit www.benefitscheckup.org.
- State Health Insurance Assistance Programs (SHIP): Offer counseling on health insurance and programs for people with limited income. Also help with claims, billing, and appeals. Visit www.medicare.gov/contacts/Default.aspx, or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's number. TTY users should call 1-877-486-2048.
- State Medical Assistance (Medicaid) office: Provides information about Medicaid. To find your local office, call 1-800-MEDICARE and say, "Medicaid." You can also visit www.medicare.gov.

RELIAS LEARNING

Toni Cesta
cestacon@aol.com

Bev Cunningham
bevcmc@hotmail.com

www.casemanagementconcepts.com