

# COLLABORATIVE CASE MANAGEMENT

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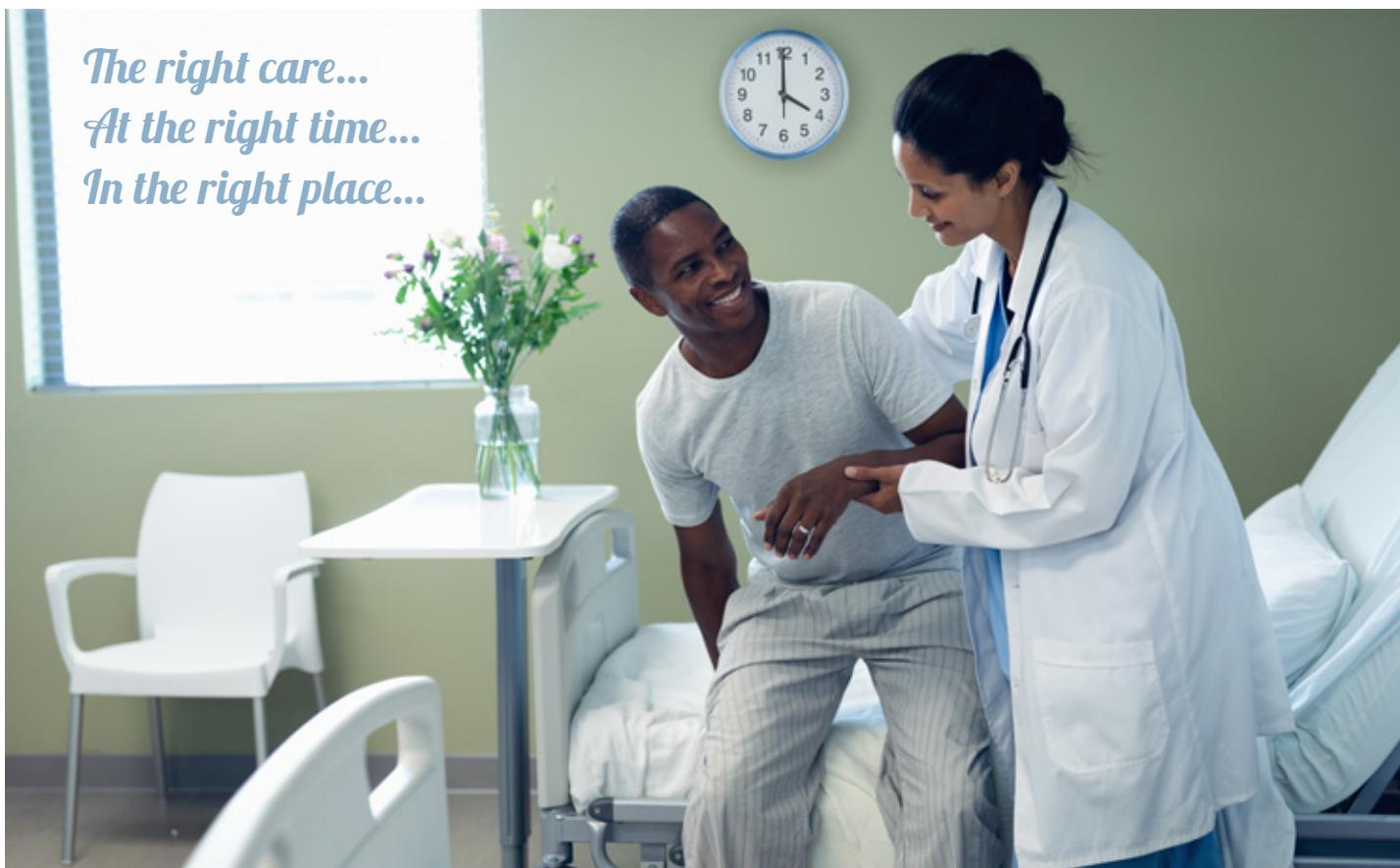


## In This Issue:

*Increasing our Understanding of  
Long Stay Patients: Results of a One-Year Study*



THE OFFICIAL PUBLICATION OF THE AMERICAN CASE MANAGEMENT ASSOCIATION



## Improving Patient Outcomes, and Reducing Stays and Readmissions Through Physician Advisor and Care Management Coordination

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Long hospital stays are shown to impact cost, efficiency and patient outcomes contributing to rising healthcare costs and potential patient risks. According to an article from *Health Catalyst*, these extended hospitalizations cost the national health system at least \$377.5 billion annually. To improve efficiency and reduce length of stay (LOS), Monument Health, headquartered in Rapid City, South Dakota, engaged in a multidisciplinary-care team approach to lower costs, improve care coordination and most significantly, improve patient outcomes by minimizing the risk of longer stays and hospital-acquired conditions, and prevent costly re-admissions.

This article will review the obstacles to a timely hospital discharge process and its adverse complications and readmissions. It will discuss the modifiable components of a care management system that can lead to redesigning the discharge process, and result in reduced length of stay, improved patient outcomes and lowered costs.

### LEARNING OBJECTIVES:

1. Examine and review key discharge processes and roles to implement and improve progression of care management in various settings.
2. Discuss measures and outcomes that demonstrate improvement of care management across the system.
3. Identify elements of a timely discharge process and the role of the Physician Advisor in progression of care.

### MEETING MULTIPLE CHALLENGES TO IMPROVE LENGTH OF STAY

In today's value-based care environment, the pressure is on to understand how to best provide efficient care while also providing quality care. Reducing unnecessary hospital length of stay (LOS) is important since this can be a drain on hospital resources, personnel and the bottom line.

Decreasing extended LOS is important for improving patient outcomes and increasing the capacity to serve growing populations. It is a key indicator of a hospital's success in achieving these goals. Additionally, the longer a patient stays in the hospital, the greater the risk he or she will become vulnerable to a healthcare-acquired infection.

## ***“Decreasing extended LOS is important for improving patient outcomes and increasing the capacity to serve growing populations.”***

Faced with these challenges, Monument Health has embraced the challenge of reducing patient LOS to lower costs and lessen risks for patients.

Monument Health includes five hospitals, eight specialty and surgical centers, more than 4,500 physicians and caregivers, and 40 medical clinics and healthcare services. The organization serves 20 communities across South Dakota and western Wyoming and receives referrals from Nebraska and North Dakota. Located in the Black Hills of South Dakota close to the Mount Rushmore National Memorial, the hospital system also cares for many tourists throughout the year from across the United States and Europe.

As the leading healthcare system offering specialized consultative care to patients in a 300-mile radius throughout South Dakota and western Wyoming, Monument Health's leadership recognized the need to lower length of stays to improve patient care delivery. By adopting a systematic, data-driven and multidisciplinary approach, the healthcare organization achieved significant results that positively impacted both costs and patient outcomes.

Like many healthcare organizations, Monument Health was struggling with long patient stays averaging more than six days. This placed undue pressure on the capacity of the system, tying up beds and staff time, along with creating diversions that caused patients and caregivers significant inconveniences.

To provide better care for this growing patient population and stay true to its mission, vision and values, Monument Health set a goal to ensure the right care, at the right time, in the right setting. That meant embracing a culture of proactive, patient-centered, and timely and efficient

care that maintained high quality across the continuum of care.

Monument Health's assessment of ways to reduce unwarranted LOS identified some major challenges, including:

- Identifying existing interruptions in a patient's flow of care that increased length of stay
- Identifying where patient-centered interventions needed to be implemented to help provide more proactive, timely and efficient care while maintaining high quality standards
- Improving a key gap in communications with providers and case managers

### ***“Monument Health set a goal to ensure the right care, at the right time, in the right setting.”***

By implementing a multidisciplinary approach that included creating a physician advisor role to serve as a medical consultant to the care management teams, the Monument Health team achieved its goal of delivering the right care, at the right time, in the right place for every patient. This innovative, systematic approach resulted in a better than anticipated length of stay reduction from 6.02 days to 4.68 days.

### **IMPLEMENTATION**

As part of the program implementation, the first step was to create a charter of guiding principles. To help inform a comprehensive strategy, the team determined it must:

- Create a plan that was patient-centered and intended to add value to the patient, family and organization
- Ensure the right care, at the right time, in the right setting
- Build a culture change of embracing proactive, patient-centered, timely and efficient care that maintained high-quality and would span across the continuum of care

To start, they formed a Patient Flow Oversight Committee focused internally

identifying patients who could be diverted without impact. The group took a personal approach placing themselves in the role of patient and/or caregiver or family member

### ***“Historically, discharge planning and length of stay were considered primarily case management issues.”***

to determine what type of care they would envision for their loved ones.

Historically, discharge planning and length of stay were considered primarily case management issues – a perception, they determined, that needed to change. They agreed on a goal: a high standard of evidence-based care – one that is well-coordinated, collaborative and team-based delivered in a safe, timely, efficient and cost-effective way.

The Patient Flow Oversight Committee included a partnership between all levels throughout the organization including case managers, providers and an internal physician advisor. The multidisciplinary team focused on creating a plan for the progression of care management and the appropriate placement of patients.

The team took a data-driven approach which included leveraging experts in the data analytics department to gain insight into the performance and processes and assist in formalizing a review of the patient length of stay. This helped the team determine where to begin. Findings from the initial assessment uncovered the following:

- There was a false belief that LOS barriers were the result of delays caused by difficulties coordinating nursing home patients
- Identification that the barriers were more tied to issues discharging patients to their homes
- Home discharges needed to be the focus for improvements
- Other areas that needed improvement included: bedside rounding, patient progression of care reviews and creating a centralized utilization review

As a result, Monument Health implemented the following:

- Mandated a patient-centered focus on the entire process
- Built a culture and infrastructure necessary to support the program's optimization
- Established an Emergency Department Case Management partnership with hospitalists. A lead case manager would act as the liaison between the providers and the multidisciplinary team
- Created an internal physician advisor role to oversee operations and the implementation of improvements
- Formed a case and capacity management plan to focus on appropriate patient placements
- Formed an SNF-ist program that called for a group of Monument Health physicians and certified nurse practitioners to provide case management and scheduling support

### TAKING A PATIENT-CENTERED FOCUS

Patients and their family members were consulted for their input from the beginning of the process to the end to provide communication tools and support to help better navigate their medical journeys.

The team launched a Progression of Care Bedside Rounds initiative partnering the nurse manager (patient's primary nurse), lead case manager and eventually the patient's primary provider along with other support team members. The team was given the authority to discuss, formulate and implement the patient's care and discharge plan as soon as possible upon hospitalization. This produced more transparency and improved patient/staff communication.

### CHANGING THE CULTURE FROM CASE MANAGER TO TEAM-BASED

Educating the providers and bedside caregivers about the new focus on early discharge planning and ensuring the vital role they would play in the process was essential to the cultural changes needed for the transformation. This was a focus shift from the existing day-to-day mode of operation. The team focused on actions they could take to create a swifter process such as changing medications from IV to oral; weaning oxygen and ensuring patients were mobilized and communicating the plan to everyone. The education also included discharge resources

including transportation options and discharge medication assistance. This streamlined the LOS avoiding an extra day for a case management team to coordinate a plan.

### PARTNERING EMERGENCY DEPARTMENT WITH HOSPITALISTS

Discovering that the emergency department with its large source of admissions had an opportunity to impact LOS, the team created an emergency department case management process to focus on readmissions, potential admissions, discharge planning and higher level of care transfers. A lead case manager acts as the liaison between the providers and the multidisciplinary team with the goal to connect patients with the appropriate post-acute care support. This work includes assigning a primary care provider, scheduling outpatient testing, home care or hospice services and to aid with medication management. The role started as five days a week coverage with on-call services on weekends but has expanded to seven days a week from 8 a.m. to 2 a.m. during peak volume times.

### ADDING A PHYSICIAN ADVISOR ROLE

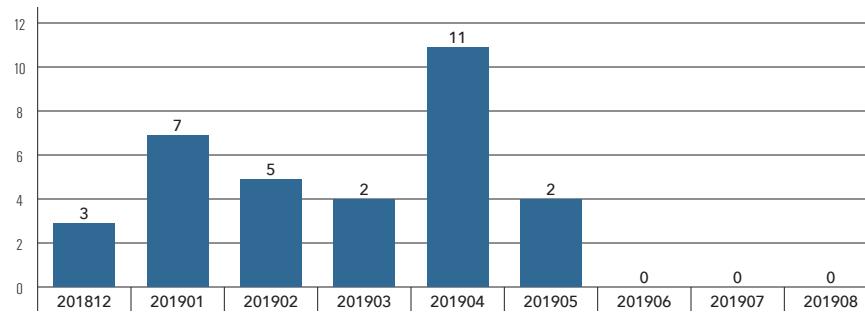
Previously, physician advisors were available to the case management team but

were utilized on-call with limited availability. Results of the assessment determined that a physician advisor was essential for the success of the LOS improvement plan.

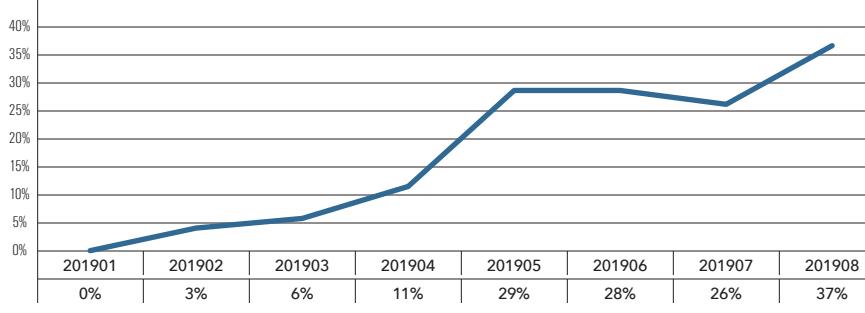
In 2018, Monument Health created the role of a full-time physician advisor to focus on streamlining the care process, providing educational support and assisting in the process improvement initiative efforts. The physician advisor became coach, mentor and educator and was tasked with helping to develop a consistent communication process between the case management team and his or herself, along with building an electronic document platform to allow for transparent communications. Additionally, the physician advisor oversees the observation process, assists in facilitating timely responses and intervenes to expedite the discharge process. Two examples include: access to stress tests on weekends and utilization of the Heart Score in decision making and PFT utilization.

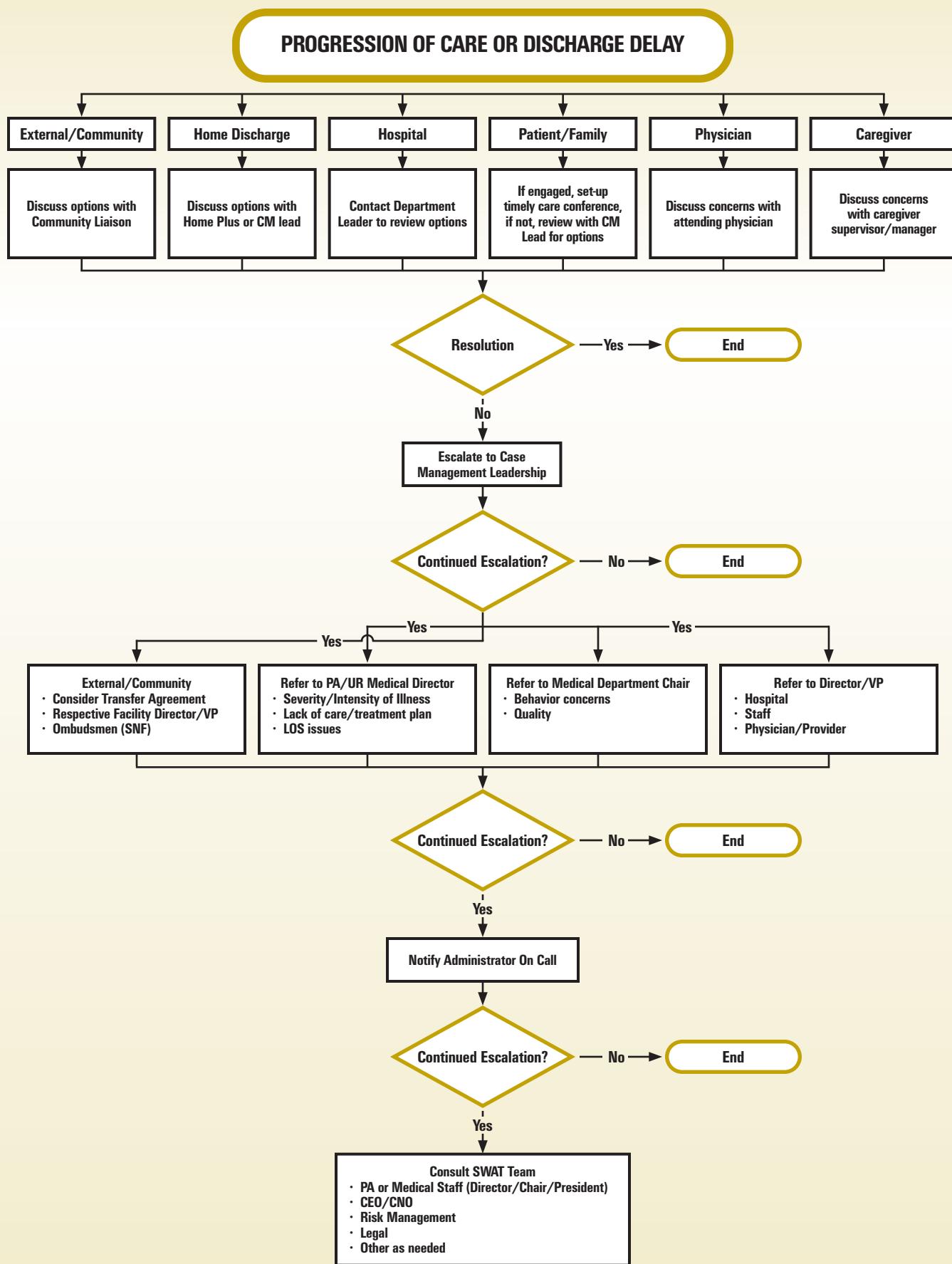
The team initiated a formal escalation process that mapped out discharge plans for complex cases. The physician advisor plays a key role in the escalation process. Barriers were identified in five key areas: including external/community, home discharge, hospital, patient/family, physician or caregiver delays.

**RCH STANDING ORDERS FOR PFT COMPLETE & PFT COMPLETE WITH ABG**



**% HEART SCORE USAGE FOR ED PROVIDERS WITH CHIEF COMPLAINT OF CHEST PAIN**





## CREATING LEAD CASE MANAGER ROLE

As the team expanded its case management services, they identified another key gap in the process which was communicating with providers. To improve communications, the team created the role of lead case manager to serve as a liaison between providers and the case management team. The lead case manager partners with three hospitalists to review patients and determine the plan for their hospitalization and discharge. The lead case manager then works with the unit-based team to facilitate the completion of the plan. Their role also includes coaching and mentorship of both the unit-based team along with community partners working on expediting complex discharges.

## OPTIMIZING CASE MANAGEMENT

From a case management perspective, there was a need to focus on a few key areas to optimize the services provided. The first focus was on implementing a diagnosis-specific plan of care which included robust guidelines for regular reviews and establishing an estimated length of stay for patients. Some of the process changes that resulted from this review include:

- Improved collaboration between skilled nursing facilities and the hospitals
- Increased focus on mobility and antibiotic usage
- Renewed awareness of both internal and external barriers to discharge

Additionally, deep dive reviews were created for real-time huddles by the case management team to examine data and focus on two significant patient populations. The first team included a unit-based weekly meeting attended by the unit manager, case manager, social worker and case management leadership. Patients being treated in the hospital for more than three days were reviewed to explore opportunities to reduce their length of stay. Patients who were hospitalized longer than 10 days were reviewed under closer scrutiny by a team that meets twice a week and includes senior leadership, case management leadership, the hospitalist medical director, lead case managers and the physician advisor to determine these more complex discharge barriers.

## IMPROVING TRANSITION MANAGEMENT

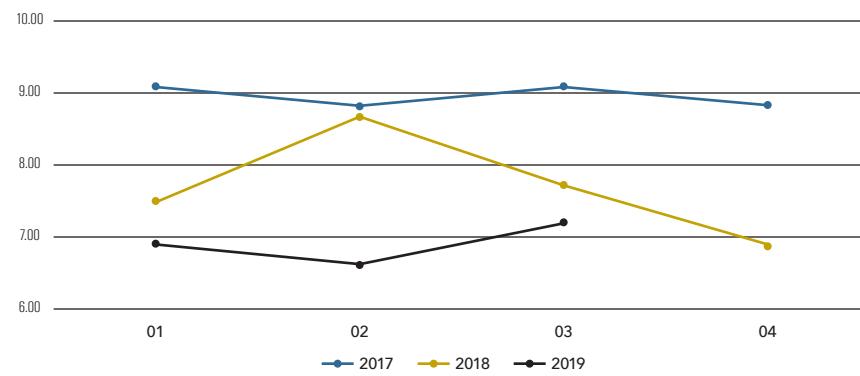
Improving the transition process was another priority. The team implemented a discharge timeout process and expanded the SNF-ist program that allowed for a group of Monument Health physicians and certified nurse practitioners to provide case management and scheduling support.

The discharge timeout process is a checklist to be completed prior to discharge to ensure that all the necessary information about the patient is included for the skilled nursing facilities. This process assigns the bedside nurse and the social worker to review orders and information before a patient's discharge. The result is a process that has greatly reduced variances in the process and improved satisfaction of both the case management team and post-acute care partners.

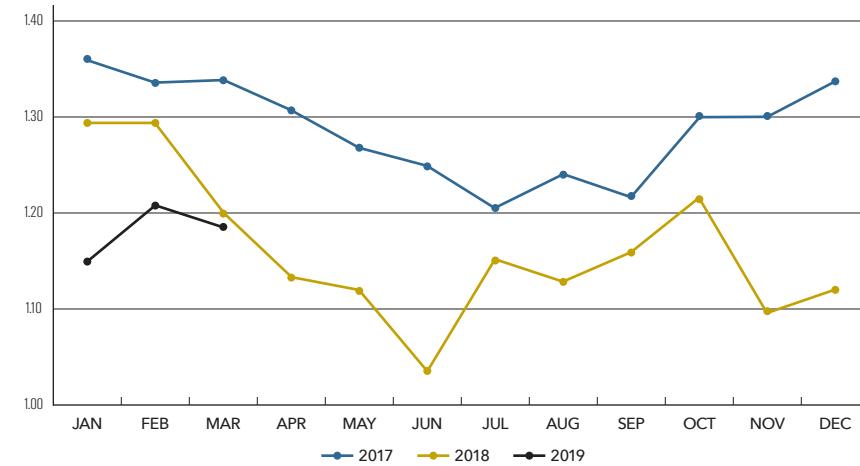
## RESULTS

- Decreased length of stay from 6.02 to 4.68 days
- Reduced transfers within the hospital and reduced diversions to other hospitals
- As patients' length of stay has decreased, hospital readmissions have also decreased
- Low readmission rates are directly linked back to the quality of services improvements
- Increased access to services for patients in neighboring communities
- Improved communication between the healthcare delivery team, patients and community partners
- Enhanced professional growth and development of teams
- Created connection to mission, vision and values

### AVERAGE LOS FOR RCH TOWER SNF DISCHARGES BY FY



### RESULTS - TOWER O/E LOS BY MONTH



## CONCLUSION

Creating an engaged, multifaceted care team approach played a significant role in lowering costs, improving care coordination and most significantly, improving patient outcomes and minimizing the risk of longer stay hospital-acquired conditions and reduced costly readmissions.

This resulted largely by forming a partnership between the case management team providers, bedside caregivers and the inclusion of a physician advisor. Additionally, the Patient Flow Oversight Committee steering committee helped drive the entire process and will continue to manage admissions, reduce diversions and manage access to service through Monument Health's communities. The committee is dedicated to patient flow and all challenges that result in barriers to improved inefficiencies.

## FUTURE OPPORTUNITIES

Future opportunities include a continued focus on providing optimal quality care to patients by placing emphasis on how they progress across the continuum of care.

Next steps include:

- Lowering readmissions
- Establishing a readmission steering team
- Leveraging data to identify specific opportunities to make a difference in the lives of patients and the community
- Creating a mobility plan for patients

*“The committee is dedicated to patient flow and all challenges that result in barriers to improved inefficiencies.”*

## ABOUT THE AUTHORS

**Nita Dunham, MS, RN, CMAC, CDP,** is System Director of Case Management for Monument Health. She has been a registered nurse for 25 years with a background in post critical care, surgical and case management. In her current role, Nita has had accountability for the hospital-based case management/social work services, utilization review, revenue integrity and the clinical oversight of our long-term care and dialysis centers.

Nita earned her master's degree in Health Services Administration from the University of South Dakota and her bachelor's degree in Nursing from South Dakota State University. She is also a certified case management administrator and holds a certification in LTC administration through the University of South Dakota. Nita co-authored an article titled, "A Hospital-to-Nursing Home Transfer Process Associated with Low

Hospital Readmission Rates While Targeting Quality of Care, Patient Safety and Convenience: A 20-year Perspective" which was published in JAMDA.

**Deepak M Goyal M.D. MBBS,** is a physician advisor at Monument Health. He graduated in 2001 from the Medical College Patiala, Punjab in India, which is one of the premier Medical Colleges in India. He moved to the United States in 2010 for his residency and graduated from Rosalind Franklin University of Medical Sciences in Chicago.

Dr. Goyal has served in various roles including primary care physician, emergency room physician, medical director and hospitalist in a critical access hospital and a nursing home in North Dakota. Subsequently, he served as hospitalist medical director in Iowa and Illinois before joining Rapid City Hospital in 2018 in his current role of physician advisor.

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