Discharge Processes to Assist in Progression of Care Management

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Objectives

- Examine and review key discharge processes and roles to improve progression of care management
- Identify key elements of the discharge timeout process
- Discuss key data elements that demonstrate improvement of care management
Today’s Speakers

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Discharge Processes to Assist in Progression of Care Management

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Andrea Anderson, RN; Nurse Manager Care Management Department
Regional Health

Regional Health is an integrated health care system with the purpose of helping patients and communities live well. The organization, with headquarters in Rapid City, S.D., provides community-based health care in more than 20 communities in two states and 32 specialty areas of medicine. As the largest private employer in western South Dakota, Regional Health is comprised of five hospitals, 24 clinic locations and employs nearly 5,000 physicians and caregivers. Regional Health is committed to the future of medicine, with medical training partnerships, a medical residency program, and more than 130 active research studies.
To make a difference. Every day.
It starts with heart.

Our vision is to be one team, to listen, to be inclusive, and to show we care. **To do the right thing.** Every time.

VALUES

- Trust
- Respect
- Compassion
- Community
- Excellence
Objectives:

Examine and review key discharge processes and roles to improve progression of Care Management

Identify key elements of the Discharge Timeout Process

Discuss key data elements that demonstrate improvement of Care Management
Transitioning to population health... A foot in more than one camp

Pay for volume
• Fragmented care
• FFS
• Treating sickness
• Adversarial payors
• Little HIT
• Duplication and waste

Pay for value
• Accountable care
• Data to drive change
• Global payment
• Fostering wellness
• Payor partners
• Fully wired systems
• Right care, right setting, right time
Then vs. Now...
The changing landscape of healthcare

An obsolete theory of the business will not be cured by procrastination; it requires decisive action


We get paid to keep people supine in bed, and we’re good at it

VS.

Our mission is to do whatever it takes to help people achieve maximum health
Medicare 2015-2020

**Current Method**

- Surgeon
- Anesthesiology
- Radiology
- Medicare
- Skilled Nursing Facility
- Home Health Agency
- Therapy Center
- Hospital

**Bundle Payment**

- Medicare
- Hospital
- Surgeon
- Anesthesiology
- Radiology
- Skilled Nursing Facility
- Home Health Agency
Rapid City LOS and Readmissions Imperative

**Why is it important?**

- Improved quality outcomes
- Increased patient safety/decrease risk of medical errors, falls and infection, financial risk to patient
- Improved patient satisfaction
- Long length of stays stress a healthcare system
- Reduce unnecessary resource utilization
- Reduce diversions
It takes a triad...
Teamwork – Progression of Care Takes Everyone!

https://www.youtube.com/watch?v=itf8lJlleiXU
Where to start?
We need to be in sync

Diversions
Progressive Bedside Rounds
Discharge Transition education for providers and caregivers
Physician Advisor Services / Escalations
Case Management Lead role
Discharge Timeout process
SNF-ist transitions
Who are the future patients? Look in the mirror ... we have to start with ourselves

What kind of care do you want for yourself and your family?

Well coordinated, collaborative, team approach... that delivers safe, timely, efficient, cost effective, evidenced based care across the continuum!
Diversions

- January = 89 Diversions
- February = 47 Diversion
- March = 48 Diversions

Each time this happens, we potentially send a community member far from home to receive services.

They could be your mother, father, Grandmother or best friend. Either way, people are counting on us!
Progression of Care Rounds

“Nothing about me, without me"
Team Rounding – Engage the Patient! “Nothing about me, without me”

Progression of the patient’s care. Team partners together to ensure that patients receive the right care, at the right time in the right setting.

**Plan for the Day**

Collaborate

**Plan for the Stay**

Communicate

**Plan for the Way**

Coordinate

Team rounding - think in terms of “what needs to happen to progress care, what barriers do we need to remove? What are the goals/milestones the patient must meet in order to discharge/transition. What needs to happen? What will we do to prevent readmission?”
Avoiding delays in progression of care - how caregivers can impact...

- Early ambulation
- If P.T. and/or O.T. evaluation needed - request as soon as possible
- Wean O2, home O2 evaluation
- Can IV’s be switched to PO?
- Advance diet per M.D.

- Test that could be performed on an output basis…ex. GI workup past neg. cath. Avoid the “while you’re here syndrome”
- Do not tell patient’s “they can stay another day if they wish”
- Know the plan
- Identify barriers to transition/discharge – talk to the patient about their goals, barriers to achieving
Physician Advisor Service: Conditions of Participation / CMS for Utilization Review Inpatient / Observation determinations

- Physician Advisor role: Initiated Nov 1st, 2017
  - Assist in progression of care oversight
  - Provide second level review
- Monday – Friday 8-4:30 partnering with interdisciplinary team
Taking the LEAD

Hospitalist / Case Manager
Lead pairing

Implementation of pilot

Outcomes reviewed every 30-60-90 days with Leadership

Completion of rollout phase
## Case Manager Lead Daily Workflow Expectations

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning huddle</td>
<td>Print Reports</td>
<td>Discuss pertinent huddle topics, Observation Report</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Payer Source, LOS Meet</td>
<td>Discuss discharges, barriers, escalations, Facility follow up with consultants</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Follow up to facilitate completion of discharge needs</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Care conference facilitation as needed</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Progressive Rounds</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Review patients per Hospitalist DC report and DC Opportunity Report</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Progression of Care follow up</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Round on CMs and SWs to provide additional guidance</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Provider afternoon huddle 1-2:00</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Coaching/mentorship of peers</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Follow up with CM/SW, Ancillary Svcs and Nursing</td>
</tr>
<tr>
<td>Morning Provider Mtg – 9:30</td>
<td>Morning Provider Mtg – 9:30</td>
<td>Address barriers and escalations</td>
</tr>
<tr>
<td>Afternoon Provider Mtg – time TBD</td>
<td>Afternoon Provider Mtg – time TBD</td>
<td>Follow up</td>
</tr>
</tbody>
</table>

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**Finish day, document, follow up on outstanding issues.**
Transitions Management

**Issue:** We were finding missing orders and lack of communication that could affect patient safety

**Solution:** Partnerships with local Skilled Nursing Facilities and Critical Access Hospitals was essential

Collaborative approach to completing a root cause analysis was completed

Variance tracking tool implemented

Identification of opportunity areas were in:

- Communication
- Discharge Orders
- Provider access
**Discharge Timeout Checklist – Swing Bed or Nursing Home**

The Social Worker will arrive 15 minutes prior to discharge to initiate the timeout procedure. Receiving facility name: __________________________ Phone number for report: __________________________

Does the facility have access to Epic?  □ Yes  □ No (If no, please refer to "Transfer Information" worksheet.)

Transfer date: ___________ Time: ___________ Mode of transportation: ___________

Oxygen for transport?  □ Yes  □ No  Nurse to send oxygen with patient?  □ Yes  □ No

Social Worker Name PRINT: __________________________ Phone number: __________________________ Disposition code: __________________________

### Nursing / HUC / PCC Tasks

<table>
<thead>
<tr>
<th>Task</th>
<th>Print Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify initiate discharge order placed in Epic (HUC / PCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notify Social Worker of order (HUC / PCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up appointment scheduled with specialty providers (HUC / PCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Print packet (Nurse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete the medication list with the next dose (Nurse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report called to facility (Nurse) - must be called prior to the patient leaving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Red Packet/Facility Information

<table>
<thead>
<tr>
<th>Medication list</th>
<th>Print Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed discharge orders lab procedures, and more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implantable device card included in blue packet (example: PCC line card)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the following to the patient in a separate packet

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge education information</td>
<td></td>
</tr>
<tr>
<td>Health summary</td>
<td></td>
</tr>
</tbody>
</table>

### Social Worker Tasks

<table>
<thead>
<tr>
<th>Task</th>
<th>Print Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order(s) for Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Wound Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Weight Bearing Status</td>
<td></td>
<td></td>
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<tr>
<td>Order(s) for Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order(s) for Diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge with Transfer Order(s) - faxed to facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Admission Screening and Resident Review (PASRR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper Rx for controlled substances for new and home medications (applies to nursing homes only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity / Diagnosis included in Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important Message from Medicare (IMM) and computer documentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

090030-20173030 Original: Receiving Facility  Copy: Send to HM
Provider Access

**Issue:** Not enough Providers to follow in LTC

**Solution:** Creation of the SNF-ist Program

- Determine communication expectations
- Educate the Social Workers and Case Managers
- Routine meetings with community facilities
- Geriatric Forum creation
Outcomes

RCRH Acute Care LOS Outcome/Expected

January 17: 1.36
February 17: 1.33
March 17: 1.30
April 17: 1.30
May 17: 1.26
June 17: 1.24
July 17: 1.24
August 17: 1.22
September 17: 1.30
October 17: 1.30
November 17: 1.32
December 17: 1.28
January 18: 1.29
February 18: 1.19
March 18: 1.13
April 18: 1.12
May 18: 1.03
June 18: 1.03
Outcomes

SD-Cohort B RIR Hospital Readmission 2017-2018

Figure 1
South Dakota Quarterly Report
Outcomes

Rapid City Care Transition Coalition Discharge Locations Hospital Readmissions Quarterly Report

Rapid City Discharge Locations Hospital Readmissions Quarterly Report
April 2017-April 2018

SNF  Home Health  Home  Hospice
Next Steps

Continued focus on progression of care issues
  • Mobility
  • Discharge process

Readmission Steering Team

Case Management within the SNF-ist Program
Questions?
Contact Information

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