Acute Enterprise Care Management

Latonia Walker RN, MSN-NEC
System Director of Care Management Operations
Advocate Health Care

• Advocate is named among the nation’s Top 5 large health systems based on quality by Truven Analytics and is the largest health system in Illinois. Our faith based, not-for-profit health system is based in Downers Grove, Illinois.

• Advocate has the largest emergency and Level I Trauma network in Illinois.

• Advocate treats more pediatric patients than any other hospital or system in the state.

• Advocate offers more than 250 sites of care, with 12 acute-care hospitals, including a children’s hospital with two campuses and the state’s largest integrated children’s network.

• Advocate has one of the largest home health companies in the state.

• Six Advocate hospitals have earned Magnet Recognition from the American Nurse Credentialing Center (ANCC) including, Advocate Illinois Masonic Medical Center, Advocate Lutheran General Hospital, Advocate Good Samaritan Hospital, Advocate Christ Medical Center, Advocate Good Shepherd Hospital and Advocate Sherman Hospital. Magnet status represents hospital-wide teamwork and dedication to creating a positive environment, which helps attract the best physicians and nurses, resulting in better overall care for our patients.

• In 2014, five Advocate Health Care hospitals, Advocate Christ Medical Center, Advocate Condell Medical Center, Advocate Good Samaritan Hospital, Advocate Illinois Masonic Medical Center and Advocate Lutheran General Hospital, were named among the nation’s Top 100 Hospitals by Truven Health Analytics.
AdvocateCare® Programs

Outpatient
Dedicated Care Managers
Multi Conditions Centers
Advanced Medical Practice
Practice Operations Coaches

Acute Care
ED Care Coordination
Inpatient Care Coordination
ED
Hospital
ED Care Coordination Optimization
Alternative Site Of Care Transitions
Readmission Risk Assessment & Focused Interventions
Inpatient Care Coordination Redesign
Acute To Post Acute Transitions

Post Acute
Hospital to Home Transition Coach Program
SNF Care Model
Palliative Care

Data & Analytics
Population Health Management
Care Coordination
## Enterprise Care Management

### Diagram:
- **Home**
- **Physician Office**
- **Emergency Department**
- **Hospital**
- **Post Acute**

### Growth
- **Data + Analytics**

### Access
- **Communication**
## Approach To Organizing Care Management & Care Delivery

<table>
<thead>
<tr>
<th>FROM...</th>
<th>TO...</th>
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<tbody>
<tr>
<td>Silo care management</td>
<td>Enterprise care management</td>
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<tr>
<td>Episodes of care</td>
<td>Value-driven coordinated care</td>
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<td>Discharges</td>
<td>Transitions</td>
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<td>Utilization Management</td>
<td>Right care at the right place at the right time</td>
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<td>Caring for the sick</td>
<td>Improving health status</td>
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<td>Production (volume)</td>
<td>Performance (value/lower cost)</td>
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Inpatient CM Areas of Focus:

- ED care coordination optimization
- Post acute transitions
- Readmission Risk Assessment and Prevention
- Inpatient care coordination redesign
ED Care Coordination Optimization

Goal - to identify best practices of ED care coordination in all of Advocate hospitals and agree upon a standard approach of evidence-based practices to:

– Prevent unnecessary admissions
– Avoid readmissions
– Ensure appropriate utilization of resources
– Improved collaboration with the ED Physicians and nurses on awareness of alternatives to admission when appropriate
ED Care Coordination Optimization Outcome:

**Deliverables:**

- Implementation of a standard set of practices for ED care coordination at all Advocate hospitals i.e.
  - ED Care Manager Orientation Checklist
  - ED Care Manager Competency
  - ED Workflow Diagram
  - Referral and Handover Process
  - ED Care Coordination FAQ’s
- Implementation of key metrics to track performance
- Patient Education - “Care Options”
Advocate Health Care System
ED CM Interventions by Type
Jan 2014 – Dec 2014

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Inpatient Care Coordination Redesign

Goal - to identify best practices of Inpatient care coordination in all of Advocate hospitals and develop a systemized standard approach to care coordination focusing on:

- Org Structure and Operational Oversight
- Roles Clarity and Accountability
- Care Coordination Activities
- Transitions with referring Provider/PCP
- Patient and Family Engagement
- Leveraging Technology /Cerner Care Management Module
Safe, Seamless, Care Transitions

• Patients face significant challenges when moving from one health care setting to another.
• Poor transitions of care can compromise patient safety and quality of care
• Focus on patients at or approaching high risk
• Manage transitions within and between settings/providers
• Better coordinated transitions can reduce unnecessary health care utilization and costs.
• Leverage Technology
System Standard Model

Standard Approach
- Transitions with Referring Providers/PCP
- Patient/Family Engagement
- Care Coordination Activities
- Roles Clarity and Accountability

Systems/Tools
- Transparency
- Data Analytics
- Leveraging Technology: Cerner CM Module

Org Structure & Operational Oversight
## First Quick Hits - Inpatient ECM Best Practices

<table>
<thead>
<tr>
<th>Huddles</th>
<th>Transition Tactics</th>
<th>Focused Reviews</th>
<th>Discharges</th>
<th>Top DRG Opportunity</th>
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<tr>
<td>Daily Huddles With PA/Hospitalist/Medical Director</td>
<td>Physician Partnered CM Model/Hospitalist</td>
<td>Daily Review Of Observation Patients</td>
<td>Priority Identification Of “Pending” Discharges</td>
<td>Targeted Focus With Action Plans</td>
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<td>Weekend “Handoff” Huddles On Friday</td>
<td>Readmission Risk Tool Meds Rec Follow-Up Appt. Patient Education</td>
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<td>Expanded Role Of Pharmacist At Discharge</td>
<td>Development Of Protocols Order Sets</td>
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- **Huddles**
  - Daily Huddles With PA/Hospitalist/Medical Director
  - Weekend “Handoff” Huddles On Friday

- **Transition Tactics**
  - Physician Partnered CM Model/Hospitalist
  - Readmission Risk Tool Meds Rec Follow-Up Appt. Patient Education

- **Focused Reviews**
  - Daily Review Of Observation Patients
  - Weekly Review Of Any Patient With LOS > 5 Days

- **Discharges**
  - Priority Identification Of “Pending” Discharges
  - Expanded Role Of Pharmacist At Discharge

- **Top DRG Opportunity**
  - Targeted Focus With Action Plans
  - Development Of Protocols Order Sets
Cerner Care Management Work-list

Prioritize/Identify ➔ Alerts ➔ Assess ➔ Implement

Streamlined Improved Efficiency
Readmission Prevention Workflow

Identify  Notify  Assess  Intervene

MPage  Discern Alerts  PowerForms  Readmission Plan of Care
# Data Analytic/Transparency

**Advocate Acute Enterprise Care Management Program Dashboard**

**Process Dashboard**

**Dashboard Date:** March 2015

## Data Range

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## MA Range

- **Sept 2014 - Feb 2015**
- **Sep 2014 - Feb 2015**
- **Jul 2014 - Dec 2014**
- **Oct 2014 - Mar 2015**
- **Oct 2015 - Mar 2015**
- **Mar 2015**
- **Oct 2014 - Mar 2015**
- **Dec 2013 - Nov 2014**
- **Dec 2013 - Nov 2014**
- **Dec 2013 - Nov 2014**
- **Dec 2013 - Nov 2014**
- **Dec 2013 - Nov 2014**
- **Feb 2015 - Feb 2016**

**Measure**

- **LDR Days Medical**
- **LDR Days Hierarchical**
- **Train Risk Adjusted (Days)**
- **Discharge Information**
- **HCAPPS Improvement**
- **HCAPPS Administration**
- **HCAPPS Staff Help**
- **Home Health Capture**
- **Medicare & MDS**
- **MDS % 0 in PAM**
- **ED Visit/week**
- **Admit/week**
- **LDR Readmission Rate**
- **Care Coordination**
- **HCAPPS Index**
- **Patient Total**

**System AdvocateCare Index**

**COAHA Goals**

% Total Discharges Isolated With Chyenes

% Total Discharges Isolated With Physician Response
AdvocateCare®
Post Acute Transitions

The Long Walk Home Just Got Easier for Advocate Patients
Post Acute Transitions: Reason for Action

- Post Acute Transition Process varies across the system
- Lack of standard practice to determine the most appropriate post-acute placement for the patient
- Lack of consistent referral process – both in terms of timing of referral and information exchanged with the post-acute provider
- Lack of standard process for transition management (inconsistent use of technology)
- Inconsistent/insufficient Patient communication
- Lack of metrics to measure the effectiveness of the post-acute transition process
Post Acute Standards

**Process Deliverables**

- Standard Criteria to determine appropriate post-acute care
- Standard data elements for referral to post-acute care
- Standard workflow using ECIN for transition management
- Standard process for offering upfront home care choice to patients

**Tool Deliverables**

- Quick reference grid and decision algorithm for appropriate post-acute care
- Pre-define data elements for referral through ECIN
- ECIN Implementation for post-acute transitions and referral management
### Transition of Care Report

This Report is not an order sheet, this is a snapshot of the patient's status prior to leaving the hospital.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>TRANSITION, TRES</th>
<th>MD/PhD:</th>
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<tr>
<td>Date of Birth</td>
<td>10/04/1990</td>
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<td>Attending MDs</td>
<td>M.A.</td>
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### Basic Patient Info

- **Age:** 73 Years
- **Unit:** CSH 260SE
- **Weight:** 80 kg
- **Allergies:** EFA
- **Amitraz:** Contact

### Injuries

- **Admission:** 01/02/2012 23:10:00, Do Not Perform CPR, Do Not Attempt Endotracheal Intubation, Do Not Attempt any Intravenous Medications, Do NOT Attempt Endotracheal Intubation.
- **Discharge Medications:** LuBan (Adult - 5W/Rehab)
- **Transportation to Facility:** General Ambulance-Essential Life Support, Private Vehicle, Private Vehicle/Care Team (0 - 5 years), Wheelchair Van, Other: General Admission.
- **Discharge Status:** Discharged, not under care of hospital staff, not authorized to return.
- **Prohibitions:** Oxygen, Tracheostomy, Atrial Fibrillation.
- **Fall/Clinical Permutations:** 7, Challenged: 01/05/12 09:04
- **Temperature:** 37.8°C, Charted: 01/05/12 11:00:52
- **Respiratory Rate:** 30 BPM, Charted: 01/05/12 08:52
- **SPO2:** 95%, Charted: 01/05/12 08:52
- **BMI:** 19.5, Charted: 01/05/12 08:52
- **SpO2:** 95%, Charted: 01/05/12 08:52

### Observations

- **Flu/Antibiotics:** Allergy/Contraindicated to Prophylactic Antibiotics, Charted: 01/05/12 09:03
- **Flu/Antibiotics:** Previously Administered This Flu Season, Charted: 01/05/12 09:00

### History

- **History:** Alert, Charted: 1/05/12 08:54
- **Orientations:** Person, Place, Time, Event, Charted: 01/05/12 08:54
- **Language:** Spanish, Charted: 01/05/12 08:54
- **Discharge/Deficit History:** Dead, Left Ear, Charted: 01/05/12 08:54
- **Discharge/Deficit History:** Clear, Charted: 01/05/12 08:54

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How do these tools help?

• Helps the team to prioritize patients with post acute needs and those that are high risk for readmission

• Creates a standard for improved handoffs and communication within the team

• Guides in referring patients to the most-appropriate post-acute care setting

• Provides a common frame of reference to the patient care team: a common understanding of post-acute programs/services

• Aids in inter-disciplinary team communication
Learning's To Date

• Managing the information becomes critical success factor in population health
• Cultural transformation takes time—new care delivery behaviors
• Creating a sense of urgency – “the train has left the station”
• Ownership and commitment to new expectations - value-based, cost-effective care
• Cannot overestimate ability and time to:
  – Balance/align interests of key stakeholders
  – Standardize processes
• Putting the patient & patient interests first
• Focus on driving value creation
  – Value = outcomes/cost
  – Right care, right time, right place, right cost
Questions?